



131.322  
A. D. POW  
~~P. 881~~





## **GROUP PSYCHOTHERAPY**

## RESEARCH STAFF

JOSEPH ABRAHAM, M.D.  
*Psychiatrist*

ALBERT E. DREYFUS, M.D.  
*Psychiatrist*

JEROME D. FRANK, Ph.D., M.D.  
*Psychiatrist*

HENRY S. MAAS, Ph.D.  
*Social Worker*

ROBERT MAC GREGOR, M.A.  
*Clinical Psychologist*

FLORENCE B. POWDERMAKER, Ph.D., M.D., *Psychiatrist*

JOSEPH B. MARGOLIN, M.A.  
*Clinical Psychologist*

HELEN T. NASH, B.A.  
*Clinical Psychologist*

MORRIS B. PARLOFF, M.A.  
*Clinical Psychologist*

DAVID ROSENTHAL, Ph.D.  
*Clinical Psychologist*

EDITH VARON, M.A., M.S.  
*Social Worker*

## COLLABORATING PSYCHIATRISTS IN CHARGE OF GROUPS

JOSEPH ABRAHAM, M.D.

CLARENCE E. BUNGE, M.D.

GEORGE F. DOYLE, M.D.

ALBERT E. DREYFUS, M.D.

JARL DYRUD, M.D.

J. H. EWING, M.D.

JOHN M. FEARING, M.D.

JEROME D. FRANK, Ph.D., M.D.

FRED HARRIS, M.D.

WILLIAM HARRIS, M.D.

W. DEAVER KEHNE, M.D.

EUGENE C. MC DANALD, M.D.

JOAN MC GREEVY, M.D.

J. D. PATTON, M.D.

A. C. RANDOLPH, M.D.

ANTHONY P. ROUSOS, M.D.

MARVIN RUDO, M.D.

HAROLD F. SEARLES, M.D.

A. F. A. STEDEM, M.D.

CHARLES STRAHAN, M.D.

WILLIAM J. TIFFANY, M.D.

EDITH I. TREPTOW, M.D.

ROBERT W. WEBB, M.D.



# *Group Psychotherapy*

## STUDIES IN METHODOLOGY OF RESEARCH AND THERAPY

REPORT OF A  
GROUP PSYCHOTHERAPY RESEARCH PROJECT  
OF THE U. S. VETERANS ADMINISTRATION

*By*

*Florence B. Powdermaker, Ph.D., M.D.*

RESPONSIBLE INVESTIGATOR

*Jerome D. Frank, Ph.D., M.D.*

PRINCIPAL ASSISTANT

In collaboration with

JOSEPH ABRAHAMS, M.D.

ALBERT E. DREYFUS, M.D.

HENRY S. MAAS, Ph.D.

ROBERT MAC GREGOR, M.A.

JOSEPH B. MARGOLIN, M.A.

HELEN T. NASH, B.A.

MORRIS B. PARLOFF, M.A.

DAVID ROSENTHAL, Ph.D.

EDITH VARON, M.A., M.S.



PUBLISHED FOR THE COMMONWEALTH FUND  
BY HARVARD UNIVERSITY PRESS  
CAMBRIDGE, MASSACHUSETTS  
1953

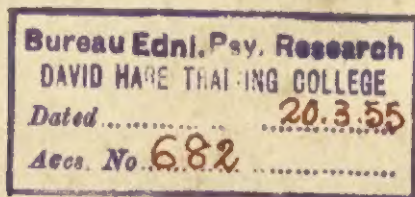
131.322

POW

COPYRIGHT, 1953, BY THE COMMONWEALTH FUND

*Distributed in Great Britain by Geoffrey Cumberlege  
Oxford University Press, London*

For approximately a quarter of a century THE COMMONWEALTH FUND, through its Division of Publications, sponsored, edited, produced, and distributed books and pamphlets germane to its purposes and operations as a philanthropic foundation. On July 1, 1951, the Fund entered into an arrangement by which HARVARD UNIVERSITY PRESS became the publisher of Commonwealth Fund books, assuming responsibility for their production and distribution. The Fund continues to sponsor and edit its books, and cooperates with the Press in all phases of manufacture and distribution.



LIBRARY OF CONGRESS CATALOG CARD NUMBER 52-10756

PRINTED IN THE UNITED STATES OF AMERICA



## *Preface*

---

THIS monograph is the progress report of a study in psychotherapy financed by the U. S. Veterans Administration and carried out under the auspices of the Washington School of Psychiatry.\* The participants are most grateful for the generous support which enabled them to undertake this stimulating adventure in collaborative research.

The report is published with the approval of the Chief Medical Director of the Veterans Administration, but the statements made by the authors are the results of their own observations and do not necessarily reflect the policy or opinion of the Veterans Administration. The two chief investigators have edited the entire report, and final responsibility for its contents rests with them. Authorship is indicated for Chapter xxiii and Appendices D and E. Certain members of the research staff assumed major responsibility for the preparation of other chapters, and their names are given in alphabetical order in footnotes. Where no names appear in connection with a chapter, it was written by the senior investigators with the assistance of the research staff.

The investigations of the research staff could not have been carried out without the cooperation of the clinical staff, who not only conducted the group meetings and attended the regular clinical seminars, but also generously participated in innumerable informal discussions with members of the research staff. The ideas which they developed from their work with patients continually influenced the course of the study.

In order to preserve the anonymity of our patients the initials used to designate the psychiatrists in charge of various groups bear no relation to their names, the patients themselves are referred to by pseudonyms, and other identifying data have been changed.

It is a pleasure to express our appreciation to the Commonwealth Fund, not only for help in arranging for the publication of this work but also for invaluable assistance in the original planning of the book and for subsequent editorial assistance. It is also a pleasure to express our appreciation to John Eberhardt, Ph.D., who participated in dis-

\*Operated by the William Alanson White Foundation of Washington, D. C.

cussions during the formative stages of the project, and to Margaret Brenman, Ph.D., and Ralph White, Ph.D., for their helpful criticisms of Part I of the manuscript. The project was also aided by Mary Touhey, who assisted in the statistical work of Part II, by Marcia E. Kensinger, social worker, Roland A. Fitzpatrick, psychologist, and John A. Powers, social worker, who participated in the observations of patients on the wards of the Perry Point Hospital.

We also wish to express our gratitude to Irene N. Margolin, Ruth Macow, Elizabeth K. Frank, and Katherine Dreyfus for help in preparation of the manuscript and to Helen T. Nash for the arduous task of preparing the index.

F.B.P.

J.D.F.



## Table of Contents

---

	<i>Page</i>
Preface .....	v
List of Tables .....	ix
List of Charts .....	xi
List of Situation Analyses .....	xiii

### Part I

#### Group Therapy with Clinic Patients

##### CHAPTER

I. Introduction .....	1
II. Studying the Processes of Therapy .....	7
III. General Description of the Research with Clinic Patients .....	38
IV. Group Composition .....	66
V. Early Meetings .....	113
VI. Group Functioning in Later Stages .....	141
VII. Dealing with Patients in the Group Setting .....	162
VIII. Resolving Tension through Rallying Topics .....	195
IX. Hostility toward the Doctor .....	205
X. Antagonism between Group Members .....	234
XI. Forms of Resistance and Their Resolution .....	254
XII. Introduction of New Members .....	281
XIII. Replacement of a Doctor .....	298
XIV. Relations between Individual and Group Therapy .....	306
XV. Doctors' Characteristics in Relation to Therapy .....	317

## Part II

## Group Therapy with Hospitalized Schizophrenic Patients

XVI. General Description of the Research with Schizophrenic Patients .....	333
XVII. Statistical Summaries .....	344
XVIII. Composing Groups of Schizophrenic Patients .....	359
XIX. Problems of the Early Meetings .....	369
XX. Rivalry Resulting from Patient-to-Doctor Relationships ..	392
XXI. Dealing with Prolonged Silences in Schizophrenic Groups	435
XXII. Dealing with Hostility and Sexuality .....	448
XXIII. The Large Group .....	466

## APPENDICES

A. Running Accounts of the First and Sixty-Fifth Meetings of the Same Group .....	495
B. The Completeness and Accuracy of the Running Account ....	531
C. The Psychiatrist's Evaluation of Individual Patients .....	549
D. The Interpersonal-Relations Interview by the Social Worker	553
E. Use of the Rorschach Method by the Psychologist .....	565
F. Evaluation of a Patient's Therapeutic Progress .....	580
List of References .....	595
Index .....	603



## *List of Tables*

---

	<i>Page</i>
TABLE 1. Comparison of Situation Analyses 39 and 26 .....	32
TABLE 2. Groups Observed at the Veterans Administration Mental Hygiene Clinic in Washington: Summary of Attendance and Duration of Treatment .....	43
TABLE 3. Evaluation of Patients' Improvement .....	63
TABLE 4. Frequency of Different Degrees of Improvement ....	63
TABLE 5. Areas of Improvement .....	63
TABLE 6. Summary of Certain Attributes of Patients in Dr. N's Groups III and IV .....	105
TABLE 7. Occasional Monopolies (Five Successful and One That Was Not) .....	<i>facing</i> 180
TABLE 8. Successful Rallying Topics .....	<i>facing</i> 204
TABLE 9. Successful Handling of Hostility toward the Doctor .....	<i>facing</i> 228
TABLE 10. Unsuccessful Handling of Hostility toward the Doctor	230
TABLE 11. Resistant Patients Who Participated as Protégés of Group Members in Whom They Perceived Similarities	258
TABLE 12. Resistant Patients Who Followed the Lead of Group Members Expressing Similar Problems .....	264
TABLE 13. Resistant Patients Who Participated after Group Members Had Criticized Their Defenses but Supported Their Underlying Problems .....	274
TABLE 14. Failure to Integrate New Patients into Established Groups .....	292
TABLE 15. Age of Patients at the Time the Experiment Was Begun	339
TABLE 16. Length of Current Hospitalization at the Time the Experiment Was Begun .....	339

TABLE 17. Diagnosis at the Time the Experiment Was Begun . . .	339
TABLE 18. Groups Observed at the Veterans Administration Hospital at Perry Point: Summary of Attendance, Duration of Treatment, and Basis of Composition . . . . .	340
TABLE 19. "Freedoms" Granted Patients from November 1947 through April 1949 . . . . .	345
TABLE 20. Special Measures Taken to Control Patients' Behavior from November 1947 through April 1949 . . . . .	350
TABLE 21. Average Number of Treatments per Month . . . . .	350
TABLE 22. Average Number of Patients Treated per Month . . . .	350
TABLE 23. Forms of Behavior Which Presented Problems of Ward Management . . . . .	353
TABLE 24. Average Number of Behavior Problems Occurring Monthly . . . . .	353
TABLE 25. Critical Ratios Between Experimental and Control Populations on Closed and Open Wards . . . . .	357
TABLE 26. Critical Ratios for Observations during the Second Year	357
TABLE 27. Proportion of Wire-Transcript Items Reported by Observers . . . . .	537
TABLE 28. Proportions of Wire-Transcript Items Reported by Observers with Varying Degrees of Accuracy . . . . .	539
TABLE 29. Proportions of Observers' Items Reported with Varying Degrees of Accuracy . . . . .	539
TABLE 30. Independent and Mutual Reporting of Meetings by 8 Pairs of Observers . . . . .	540
TABLE 31. Extent of Agreement between Paired Observers on Items Mutually Reported . . . . .	541
TABLE 32. Agreement in Sample Records, by Topic Analysis . . .	547
TABLE 33. Agreement in Sample Records, by Item Analysis . . . .	547

## *List of Charts*

---

	<i>Page</i>
CHART 1. Distribution of 124 Patients by Age .....	41
CHART 2. Doctors' Evaluation of Type of Treatment for 62 Patients Who Improved .....	59
CHART 3. Degree of Improvement as Related to Duration of Observed Treatment .....	60
CHART 4. Reasons for Patients' Leaving Group Treatment .....	79
CHART 5. Number of Packs and Tubs Given in Experimental and Control Wards, November 1947–April 1949 .....	351
CHART 6. Number of Electric Shock Treatments Given in Experimental and Control Wards, November 1947–April 1949	351
CHART 7. Episodes of Incontinence, December 1947–April 1949	352





## *List of Situation Analyses*

---

	<i>Page</i>
CHAPTER IV. Group Composition	
Situation Analysis 1 .....	70
CHAPTER V. Early Meetings	
Situation Analysis 2 .....	125
CHAPTER VII. Dealing with Patients in the Group Setting	
Situation Analysis 3 .....	166
Situation Analysis 4 .....	169
Situation Analysis 5 .....	171
Situation Analysis 6 .....	173
Situation Analysis 7 .....	175
Situation Analysis 8 .....	178
Situation Analysis 9 .....	186
Situation Analysis 10 .....	188
Situation Analysis 11 .....	192
CHAPTER VIII. Resolving Tension through Rallying Topics	
Situation Analysis 12 .....	195
Situation Analysis 13 .....	199
Situation Analysis 14 .....	200
CHAPTER IX. Hostility toward the Doctor	
Situation Analysis 15 .....	207
Situation Analysis 16 .....	210
Situation Analysis 17 .....	211
Situation Analysis 18 .....	213
Situation Analysis 19 .....	216
Situation Analysis 20 .....	218
Situation Analysis 21 .....	220
Situation Analysis 22 .....	222
Situation Analysis 23 .....	226
CHAPTER X. Antagonism between Group Members	
Situation Analysis 24 .....	241

	Situation Analysis 25 .....	243
	Situation Analysis 26 .....	245
CHAPTER XI.	Forms of Resistance and Their Resolution	
	Situation Analysis 27 .....	254
	Situation Analysis 28 .....	256
	Situation Analysis 29 .....	260
	Situation Analysis 30 .....	262
	Situation Analysis 31 .....	266
	Situation Analysis 32 .....	268
	Situation Analysis 33 .....	270
CHAPTER XII.	Introduction of New Members	
	Situation Analysis 34 .....	282
	Situation Analysis 35 .....	286
	Situation Analysis 36 .....	288
	Situation Analysis 37 .....	290
CHAPTER XIV.	Relations between Individual and Group Therapy	
	Situation Analysis 38 .....	311
	Situation Analysis 39 .....	313
CHAPTER XX.	Rivalry Resulting from Patient-to-Doctor Relationships	
	Situation Analysis 40 .....	399
	Situation Analysis 41 .....	400
	Situation Analysis 42 .....	401
	Situation Analysis 43 .....	402
	Situation Analysis 44 .....	404
	Situation Analysis 45 .....	406
	Situation Analysis 46 .....	409
	Situation Analysis 47 .....	410
	Situation Analysis 48 .....	412
	Situation Analysis 49 .....	416
	Situation Analysis 50 .....	418
CHAPTER XXI.	Dealing with Prolonged Silences in Schizophrenic Groups	
	Situation Analysis 51 .....	442
	Situation Analysis 52 .....	443
	Situation Analysis 53 .....	445
CHAPTER XXII.	Dealing with Hostility and Sexuality	
	Situation Analysis 54 .....	448
	Situation Analysis 55 .....	451



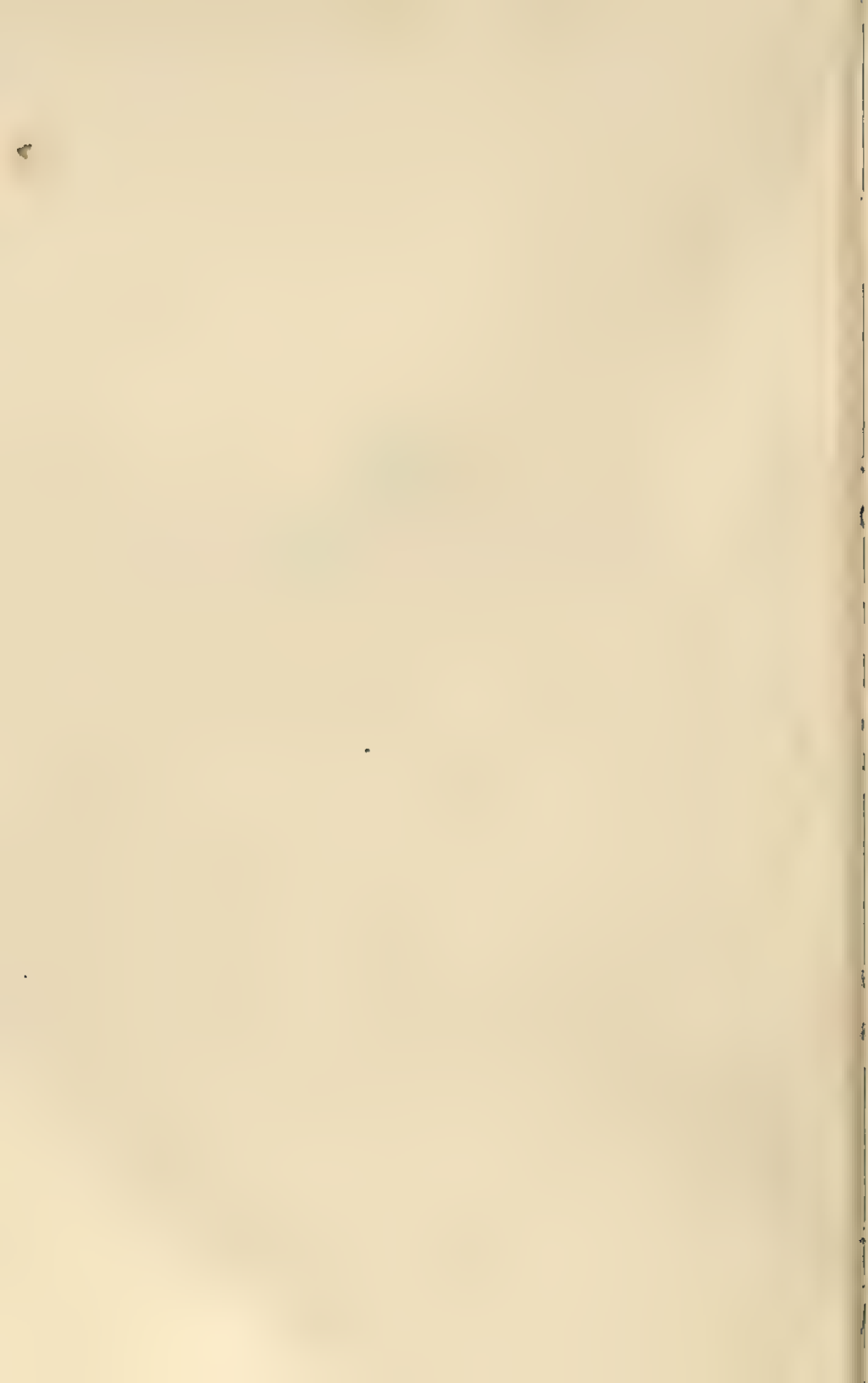
Situation Analysis 56 .....	452
Situation Analysis 57 .....	453
Situation Analysis 58 .....	454
Situation Analysis 59 .....	455
Situation Analysis 60 .....	458
Situation Analysis 61 .....	462
Situation Analysis 62 .....	463
Situation Analysis 63 .....	464



## **PART I**

### ***Group Therapy with Clinic Patients***





## CHAPTER I

### *Introduction*

---

GROUP psychotherapy, as far as its history can be determined, had its inception in the observation that hospital or clinic patients with similar medical and psychological problems may receive benefit from one another as well as from a doctor. The dynamics of the processes by which the beneficial effects took place were not clear, nor was it specifically known in what manner and to what degree patients received mutual support. But it was obvious that, if successful, group therapy could effect much-needed economy. During the war the prevalence of psychological disabilities in numbers far too great for concentrated individual attention made the use of group treatment practically a necessity, and after the war interest in this method of treatment continued to increase. The Veterans Administration in particular was faced with the problem of caring for large numbers of mental patients with relatively few psychiatrists. Therefore, since the chief investigator of the present study (then a member of the Veterans Administration staff) had had experience in practicing group therapy and in supervising group therapists, it seemed worth while to this organization to sponsor research in the use of such treatment for both hospital and clinic patients.

The project was divided into two sections. One was carried out at the Veterans Administration Mental Hygiene Clinic in Washington (from July 1947 to December 1948) and consisted of groups of neurotic patients and a few ambulatory schizophrenics. The other was carried out at the Veterans Administration Hospital at Perry Point (from July 1947 to May 1949), where chronic schizophrenic patients who had not responded to routine hospital care or shock treatment were divided into two matched wards, one receiving psychotherapy

in groups, the other not. A group of less chronic patients was also observed at Perry Point.\* Although for obvious reasons the research scheme and the therapeutic method used at the hospital differed somewhat from that used at the clinic, the general philosophy was the same. The clinic and hospital were served by the same psychiatric social workers, but each institution had its own staff of psychiatrists and clinical psychologists. There were frequent conferences between members of the two sections.

The project had the services of twenty-four medical doctors (of whom ten were psychiatrists and the rest were psychiatric residents): five clinical psychologists; and two psychiatric social workers. An analytically trained psychiatrist who had practiced group as well as individual therapy exercised over-all supervision (Florence B. Powdermaker). A psychiatrist trained in psychological methodology took immediate charge of the research and also conducted groups (Jerome D. Frank). A psychiatrist experienced in group therapy with psychotics participated on a part-time basis (Joseph Abrahams).

It was arbitrarily decided that the therapist of each group should be a psychiatrist or psychiatric resident and also a volunteer. At the beginning it was thought that lack of clinical experience on the part of some of the psychiatrists would be a handicap. But as matters turned out this proved to be an advantage. Some problems were brought into sharper focus and others were shown to be common to experienced and inexperienced therapists. Above all, the project was served by a group of doctors who approached therapy with eagerness to learn and without preconceived ideas and rigid attitudes.

The clinical psychologists and social workers, by whom the patients were respectively tested and interviewed, were chosen for their interest in research and their ability to orient themselves to the project. At the clinic the role of observer at the regular meetings of each group was assigned to a psychologist or social worker. At the hospital psychologists and social workers shared this duty with psychiatrists.

\*In addition, a number of schizophrenic women patients at St. Elizabeth's Hospital were treated in a group with their mothers. The results of this part of the research will be reported separately by Abrahams and Varon in a monograph entitled *Maternal Dependency and Schizophrenia* (New York, International Universities Press, in press).



Thus all members of the research staff participated by leading or observing groups. This dual function broadened their understanding and helped to integrate the two aspects of the investigation.

Four types of discussion provided bases for collaboration:

1. A seminar that included supervisory psychiatrists, psychiatrists who led groups, and their observers. This grew out of a discussion group organized in the fall of 1946 for informal discussion of literature on the psychology of group behavior and methods of research in the field. The meetings continued for the duration of the project, and once the clinic and hospital groups had been formed the discussions became largely concerned with therapeutic problems arising therein. Tentative principles of treatment were formulated and later subjected to validation or revision. Discussions were guarded at the start, but members became increasingly comfortable and free. No attempt was made by the seminar leader or members to discuss the personal problems of the group leaders, but sometimes, in discussing the problems of their groups, leaders would bring out the personal reasons for their difficulties.
2. Meetings of the supervisory psychiatrists with non-medical research staff in which procedures of study and ideas for changes in research methodology were examined and developed.
3. Discussions after each group meeting between the group leader and his observer of major occurrences and their interpretation, and of the tentative goals of the next meeting.
4. Evaluation conferences on each patient, always held at the end of the observed period of therapy and sometimes at the beginning. The psychiatrist in charge of the patient's group, the psychologist who tested him, the social worker who interviewed him, and the observer assigned to his group all participated.

The presence of people trained in three different disciplines created problems of communication because of special vocabularies, differences in approach, and questions of status. But since all were concerned with the same problems and increasingly respected each other's contributions, misunderstandings and rivalries diminished and genuine collaboration increased as the number of concepts held in common grew. Everyone participated in this mutual training process. The

staff's varied experience in psychiatry, psychology, and sociology, both as research and as clinical workers, added breadth to its thinking.

Because of the rapid development of psychiatric thinking and practice, numerous schools of group therapy have arisen; these vary greatly in procedures and goals and in the background and training required of therapists. Every type of psychological approach from exhortation to a modification of psychoanalysis has been practiced by lay workers, psychologists, social workers, internists, and psychiatrists. Although the literature is voluminous, the actual body of established knowledge is small.<sup>o</sup> We have not summarized the references, as this has been adequately done by others, notably Burchard<sup>1</sup> and Klapman.<sup>2</sup>

In initiating our project it was obviously impossible to investigate with any degree of thoroughness the numerous types of group therapy being practiced. In fact, observation and study of more than one method would have enlarged and complicated our research to an unmanageable degree. In view of our experience and also, we believed, in the interest of our patients, we therefore decided to limit ourselves to the type of therapy which may best be described as analytic in orientation. That is, in general, we proposed to help our patients analyze their unsatisfying attitudes and behavior to the degree necessary to resolve their conflicts and relieve their symptoms. We also believed that the analytic approach gave considerable promise of adding to our knowledge of the dynamics of group interaction in its relation to therapy.

Our approach to group therapy with neurotic patients had points in common with that of Foulkes,<sup>3</sup> Ackerman,<sup>4, 5</sup> Slavson,<sup>6</sup> and Wolf,<sup>7</sup> and we were influenced in our thinking by Schilder's<sup>8, 9</sup> analytic concept and Trigant Burrow's<sup>10</sup> emphasis on the study of group interaction. We were stimulated by Bion's<sup>11</sup> descriptions of the group process but avoided his exclusive attention to it. Although our groups were not social clubs as were Bierer's,<sup>12</sup> the leadership was completely informal. We differed from Schilder,<sup>8</sup> especially, in not using questionnaires and set tasks, and from Wender,<sup>13</sup> Klapman,<sup>2</sup> and Lazell<sup>14</sup> in that in no case did the psychiatrist in charge give case histories or systematic presentation of psychiatric concepts. He encouraged inter-

<sup>o</sup>See the List of References following Appendix F.

actions among patients. He helped them to examine their attitudes and behavior toward one another (*process*) as well as the personal material which they presented (*content*).<sup>9</sup>

Our therapeutic goals differed in no wise from those of psychotherapy in general. The degree of change hoped for depended in each case on the patient's own goals and the psychiatrist's evaluation of the severity of the patient's disturbance and his potentialities for improvement. On the whole, our doctors erred in the direction of over-ambitiousness, with the result that patients were sometimes kept in therapy after further improvement seemed unlikely. This tendency to set the therapeutic goal too high was due chiefly to a desire to see just how much could be achieved by group treatment.

The same philosophy guided our approach to schizophrenic patients, but their grossly distorted ways of communicating and behaving presented the psychiatrist with special problems. How these were met depended largely on the training and personal characteristics of the individual doctor, but on the whole the same principles of therapy held. In general our approach was similar to that of Mann and his colleagues.<sup>15</sup>

When there was a conflict, therapy was carried out in the light of the patient's needs rather than the interests of research. But it was agreed that each psychiatrist should conduct his group in the way that was most natural for him within the limits of the type of therapy outlined above. Consequently, many differences of approach arose from personality and previous training, and many changes in techniques were made as the investigation progressed. As a result of staff conferences, these differences tended to converge.

Our techniques for evaluating individual patients and for studying the processes of therapy were, in H. A. Murray's terms,<sup>16</sup> organismic rather than elementaristic in orientation. They were designed to cast light on therapeutic problems and on the relation between the patients' characteristics and the therapeutic processes, to evaluate the effects of therapy, and to provide later criteria for defining group composition. Early efforts to study the processes of therapy by categorizing and rating them proved misdirected. A more fruitful approach, we found,

<sup>9</sup>For definitions of *process* and *content*, see Chapter II.

was to single out and describe patterns of change involving individual patients, the group, and the doctor.<sup>17</sup> The descriptions we called situation analyses. Those dealing with similar patterns were systematically compared to isolate the essential factors involved. An attempt was also made to describe systematically some of the gradual long-term changes in significant attitudes and behavior as therapy progressed.

In order to obtain comparable pictures of the patients before and after treatment, the usual psychiatric social-work interview and methods of evaluating psychological tests were modified. At the hospital, methods were devised for observing and comparing the behavior of patients under treatment with the behavior of those used as controls.

In reviewing the material gathered in our research it soon became obvious that only a relatively small part could be analyzed. We therefore decided to limit ourselves to the study of the problems of therapy which were of most immediate concern to the doctors and on which we had the most material. We regret that time did not permit us to develop formulations in regard to the pathology of schizophrenia and schizophrenic relationships and communication, since we have the impression that, as compared with individual therapy, group therapy gives a wealth of insight into these problems.

To sum up—after a preliminary explorative discussion, we worked on two sets of problems at the same time. One was concerned with isolating and studying specific problems as experienced by the psychiatrists conducting group therapy and with testing different ideas and techniques and modifying them as indicated. Here our aim was to develop an objective method of studying group therapy that would enable workers in this field to achieve a qualitative understanding of its processes. The other set was concerned with devising methods of research which were sufficiently valid to give us the answers to the problems we were studying.



## CHAPTER II

### *Studying the Processes of Therapy*

---

THE systematic study of psychotherapy involves many knotty problems. In fact, it may be that some crucial aspects of psychotherapy—whether group or individual—cannot be communicated in objectively verifiable terms. For example, as yet undefinable aspects of the therapist's personality may be more important for his results than the technique he says he uses.<sup>1</sup>

Assuming that objective study of therapy is possible, serious difficulties arise from the fact that the therapist—whose observations are indispensable since he has the most intimate knowledge of the patient—is himself involved in the process he is observing. As his emotions are inevitably involved in the treatment of his patients, his perception and memory are bound to be distorted to an unknown degree. Moreover, the effort to keep a record during the treatment session, or to note what is occurring so as to recall it afterwards, may modify the therapist's activity to an indeterminate extent—impeding, for instance, his free association to what the patient says.

A further difficulty in studying the processes of therapy is posed by the impossibility of repeating experiments or observations on the same phenomena. As no two people are alike, obviously the same observation cannot be repeated on different people. Moreover, the same observation cannot, strictly speaking, be repeated on the same person, because the situation is inevitably modified by the initial observation and the passage of time. Above all, the fact that one is working with human beings makes it impossible to maintain a rigid experimental design. Patients' desires and activities are not at the disposal of the experimenter, and it is seldom possible to wait for patients of the exact types needed to fill out a preconceived plan. In short, unpredict-

able and uncontrollable circumstances can be counted on to interfere with any project that involves a period of time comparable to that of research on psychotherapy.

An attempt to circumvent these difficulties by using statistical methods runs into other problems. For instance, in order to set up statistical controls for evaluating psychotherapy, one must use either some principle of random selection (e.g., every other patient) or matching. The first is not feasible in most situations involving psychotherapy because the sample is not large enough, whereas matching presupposes that one knows which attributes to match. Furthermore, statistical methods have at best only limited applicability to psychotherapy because they cannot take into account the *Gestalt* nature of the process.

While these difficulties make experimentation or statistical studies of psychotherapy very difficult, they do not, of course, mean that scientific study of this field is impossible. As Cohen and Nagel<sup>2</sup> have pointed out, "scientific method is simply the way in which we test impressions, opinions or surmises by examining the best available evidence for and against them." Experimental and statistical methods do not create insights; they merely verify them. It seems to us that, in the field of psychotherapy, preoccupation with controls and experimental design is premature and is based on the misapprehension that these methods in themselves lead to the discovery of significant relationships.

There are researchers on human behavior who have refrained from investigating clearly defined and socially urgent problems because they saw quantification as a necessary tool and precise measurement as a *sine qua non*. We, however, are of the opinion that the human behavior must be recorded and studied in different situations and that a collection of discrete traits or functional measurements would not produce a representation helpful to our understanding of the individual. At a descriptive and exploratory level, quantification would provide merely the guise of science. In the present study we finally came to rely primarily on data obtained by specially trained observers working in close collaboration with the psychiatrists who were in charge of groups. The data were analyzed along qualitative rather than quantitative lines.

### THE OBSERVER AS AN INSTRUMENT OF RESEARCH\*

The clinical psychologists and psychiatric social workers who functioned as observers had three primary duties in addition to their study of individual patients: (1) recording from direct observation of group meetings the verbal and non-verbal communications exchanged, the interrelationship of focal events, and the changes that occurred from meeting to meeting; (2) conferring with the psychiatrists immediately after each meeting; and (3) subsequent analyses of the data. They also had the responsibility for getting from the psychiatrists further information pertinent to the research and for participating with them in seminars. We think that a brief account of the time consumed in carrying out these duties may be useful to others in planning research.

The group meetings held at the clinic averaged an hour and a half. The observer spent half an hour in discussion with the doctor after each meeting, and (as the project developed) another half-hour preceding the meeting. Each session, therefore, took two and a half hours. The time consumed in analyzing the meeting before dictating the account of it varied with its complexity and the observer. It was seldom possible to complete a record in less than three hours, and usually more time was needed—an especially difficult meeting might take two days to write up. The interviews between social worker and patient took about an hour and a half to record, and at least two hours to analyze and write up. From one and a half to two hours were required to give the psychological tests and about six hours to interpret them. At the hospital from six to eight hours a week were spent in observation, ten hours in discussions with the doctors, and fifteen in writing reports. Administrative details, which are more complicated in a large hospital than in a clinic, took at least four or five hours a week.

Very early in our experience it became clear that regular meetings of the research team would be necessary to keep our thinking coordinated. At least two hours a week, and frequently twelve hours or more, were spent in conferences. The observers formulated ideas about the functioning of groups or the methodology of the research.

\*Major contributors: Henry S. Maas and Edith Varon.

Ideas which seemed valid would then be tested. Those which were retained were thus the product of the team as a whole rather than of an individual.

### *The Observer's Relationship with the Doctor*

The observer was assigned to one or more groups which he attended regularly. As previously stated, the doctor and observer met for half an hour after each session and sometimes before, to discuss significant events of the previous meeting. They discussed the intent of certain of the doctor's interventions and how the intent corresponded with the observed effects. The behavior of the patients and its possible meaning were talked over. Events were reviewed to determine whether they could be used in situation analyses. If there was no consensus, particularly regarding situation analyses and the meaning of patients' behavior, the material was not used. Problems which might confront the doctor in the next meeting and his plans for dealing with them were considered.

Consideration was sometimes given to alternate ways in which the doctor might have handled a situation and which he might try in subsequent meetings under similar circumstances and attempts were made to predict their effects. This, like trying to reach a consensus, was an effort to increase the validity of our interpretation. For instance, in one meeting Patient A made an apparently friendly advance to Patient B by saying that he knew how the latter felt; the second patient reacted angrily to the superior tone of voice in which this was uttered. The doctor discussed with the first patient his patronizing attitude. In the post-meeting discussion it was agreed that the second patient had singled out the superior tone of voice as a way of rejecting a friendly overture; and the doctor successfully brought this out with him in the next session.

As a result of these regular discussions, a relationship grew up which helped or hindered both research and therapy. This relationship varied as the doctor redefined his use of the observer and how he felt about him. Similarly, the observer had to be aware of his feelings toward different doctors at different times and of pitfalls of the relationship.

For most doctors group therapy was more taxing and complicated



than individual treatment because of the greater complexity of the group situation and their lack of experience in dealing with several patients simultaneously. Some felt the need to express their feelings after a meeting. If the doctor was insecure, he might look to the observer for reassurance and guidance. He might depend on the observer to point out techniques which he used repetitively and without effect, personal reactions, such as defensiveness, of which he was unaware, and cues which he had missed. Unfortunately it happened on occasion that a doctor unconsciously tried to use the observer as a control analyst, or the latter assumed this role.

The observer's presence provoked anxiety in varying degrees. Some doctors refused to have an observer present until they felt more secure. One doctor described what appears to be a common phenomenon: "I project my own critical super-ego on the observer." As a result of such projection, some doctors anticipated sharp criticism. In extreme instances they were unable to forget the observers, and their style of therapy was at times determined in large measure by what they thought the observers expected of them.

The anxiety of several doctors was increased by questions asked by the observers—questions suited to the needs of the research rather than the doctor. This was particularly true of questions about the goals for the meeting, which in many cases the doctor was unable to formulate. Only at the end of the study could they tell the observers of their irritation. They were also sensitive to questions which seemed to be aimed at their faults rather than at understanding of their therapy. For example, observations on the early meetings of the first group to be started at the hospital became the subject of teaching discussions. Subsequently, whenever the observer was absent, the doctor reported that he had had "a real good meeting" and said that he felt "restrained" when observers were present.

At the clinic one doctor displaced his anxiety over his own effectiveness by stating that the observer had upset the meeting. Another manifested his ambivalence by complaining that he had to wait too long for the records of his meetings. A third, after a year and a half, finally admitted that he enjoyed the observer's absence. On the other hand, three of the doctors initially used their observers as the recipi-

ents of frank expression of feelings of success or failure following a group meeting; these feelings seemed so pertinent that the observers regularly started the discussion by asking about them. One doctor clearly looked on the observer as his surrogate, asking him on a few occasions to open the meeting when he expected to be late. In time, all the doctors came to value the observers and to look on them as a liaison with the research staff. They appreciated the observers' reviews of the reports and the ratings of each patient which they made for the study.

Occasionally an observer had preconceived ideas or developed theories about group therapy which he thought were superior to those of the doctor. He noted what seemed to him to be mistakes and was eager to teach the doctors better ways. Although the observer's insights were often of great value to the doctor, the expression of them had to be guided by awareness of the doctor's anxiety and insecurity on one hand and the observer's tendencies to usurp the therapeutic role on the other. In practice, the relationship generally developed into one of cooperation and proved of advantage to both. All but one of the doctors at the clinic reported at the end of the study that they would want observers in any future group therapy work.

### *The Observer's Relationships with Patients*

The observer's presence might, of course, introduce special problems into the therapeutic situation. At the hospital he sat in the circle of patients and doctor. At the clinic he sat at a short distance from the table around which the doctor and patients met. A microphone hung over the center of the table; the observer had a wire recorder by his side and sometimes used earphones for clearer audition. The ease with which the group accepted the observer seemed to depend on the doctor's attitude. If the doctor accepted the observer easily, the group apparently followed suit. When a certain group had been running for some time at the clinic, the patients began to give evidence of positive attitudes toward the observer. At Christmas time, for example, after about nine months' of meetings, a patient drew a book of cartoons including patients and doctor, and also the observer, who was made to say, "I'm not supposed to talk, but anyway I'll say 'Merry Christmas.'"

Although the observers almost never talked during the meetings and tried to remain inconspicuous and apart, there was ample evidence that they had meaning for many of the patients in both clinic and hospital groups. On one occasion, when an observer returned to a group, he was greeted with, "Welcome back" and "I thought we had really lost you." On another occasion, a patient turned away from the doctor, saying, "I want to ask Mr. Y (the observer) something," his apparent intent being to cut out the doctor. Often patients regarded the observer as an adjunct to the doctor or a substitute for him when the latter was absent. Occasionally they looked to the observer for responses at times when they might have called on the doctor. In such an event, the observer referred them back to the doctor in an attempt to keep his own role and that of the therapist clearly defined in their minds.

The observer also occasionally appeared to have a meaning for the patients distinct from his connection with the doctor. Particularly in the early meetings of the group patients might greet the observer as they entered or left. Sometimes the observer might become an object of resentment to the group, particularly in a period preceding open expression of hostility to the doctor. Comments in the clinic groups might range from general attacks on social workers and psychologists to specific objections to "Mr. X, always writing in the back there." In the hospital groups patients might sit next to the observer, watching him and making sarcastic comments on what he was doing, such as, "Did you get that down?" In one group, a psychotic patient threatened to attack the observer. In another, the patients made fun of his name.

Evidence in one group, when the observer was absent for the first time, suggested that recording might facilitate patients' therapeutic activity; in this meeting the content was superficial and the atmosphere was relaxed, the patients stating that the session was less significant than usual because there was no record of their behavior. One patient thought that the disappearance of the observer indicated that the doctor had lost interest in the group.

While the use of a woman observer in groups of men might initially inhibit patients from talking freely, it was generally found that encouraging the patients to discuss their feelings about her facilitated

their acceptance of her and might be useful therapeutically. This problem was not satisfactorily studied. Those visitors whose reason for being there was clearly defined and appropriate—for example, a visiting psychiatrist—seemed to have less effect than those whose role was unclear. Visitors seemed to be inhibiting if they showed any emotional reactions.

Occasionally an observer tended to identify with a patient, seeing the group through the eyes of this patient and with an emotional reaction which might affect his awareness of what was occurring. For example, one observer tended to identify with a patient who demonstrated what he considered to be his brilliance and mastery of psychiatric techniques to other patients. For some time the observer regarded this patient with such respect that he thought of him as a therapist; when he reminded himself that the man was really a patient, he recognized the latter's behavior as neurotic and was able to discuss it without distortion. Another observer shared the group's irritation and frustration with a patient who stammered. This made him less efficient in recording the meeting and left him fatigued at the end. He recovered his objectivity by reminding himself that the stammering was something for the group to deal with.

### *The Observer's Qualifications*

It is apparent from the preceding discussion that a primary interest in research is an outstanding requirement for an observer. He should have sufficient training in dynamic psychology to be able to catch changes as they take place and to understand something of their meaning in relation to the individual patient and the group. He should have sufficient self-discipline to be able at the same time to focus consistently on the meeting, to keep the record, and to note those passages which require discussion with the doctor, either because they seem significant or because they are unclear. The need for self-discipline is stressed because the content of group meetings is such that observers may find themselves free-associating about their own problems or reacting with such anxiety that they are temporarily unable to follow the situation at hand.

The role of the observer is a taxing one, and he is frequently sub-



jected to temptations to step beyond its bounds. He must guard against assuming a therapeutic or personal relationship with patients or a supervisory or competitive role with the doctor. He is helped to remain within bounds by his awareness of the dangers implicit in doing otherwise, his interest in research, and his conviction of the importance of his work.

#### METHODS OF RECORDING AND ANALYZING THE PROCESSES OF THERAPY

Methods of observing and analyzing the processes of therapy were our first concern and continued to constitute a major problem. It might be argued that ideally the raw material for analysis should be a record of everything that occurred at the group meetings, including not only what was said, but the intonation and gestures accompanying it, as well as other non-verbal communications such as postural changes, autonomic evidences of emotional tension, and so on. But only sound films could supply such a record, and it was technically impossible to make these. At first the next best method appeared to us to be a wire recording which would contain all the verbal material of each meeting and some indication as to the emotion with which it was expressed. However, trials soon convinced us that study of the complete mechanical recording presented essentially the same problem of selecting and describing significant events as observation of the original meeting while missing the liveliness and sense of reality of the non-verbal communications, which were often very significant. In fact, mechanical transcriptions, whether sound films or wire recordings, failed to indicate relationships between events.\*

Moreover, from the purely practical point of view, complete recordings of any nature were too unwieldy for our purpose. Besides being immensely laborious to transcribe, the amount of material in a project

\*See discussion of Gill and Brenman,\* which stresses that the therapist's understanding of "emotional intercommunications" cannot be replaced by sound movies or other technical aids. Through our use of the observer's post-meeting interviews with the psychiatrist, the latter's otherwise unspoken predictions, goals, and hypotheses about treatment were also recorded among the inferences and summary of each meeting. These, Gill and Brenman say, "may prove the central methodological tool in clinical research."

the size of ours would soon have become so enormous that it would have become impossible to study more than random samples. The latter were obviously unsatisfactory in view of the fact that the process involved was one in which phenomena to be observed were unpredictable and of unequal values as potential determinants of subsequent events. In many cases continuity would be lost and the phenomena which were not recorded might often be those which were crucial for an understanding of *sequelae*.

As the project developed, we decided that although the trained observer was the best recording instrument, a wire recorder could be profitably used to supplement and check the observer's report.

The observer's method of selecting material for the record and the way it should be recorded were closely connected problems. We had to choose between a systematic coverage of certain aspects which had been decided upon in advance and a free narrative account of what seemed significant to the observer. We lacked sufficient personnel to do both. Originally, some members of the research group thought it would be possible to adopt the standardized observational methods used by Bales<sup>4</sup> and Kurt Lewin's co-workers<sup>5, 6</sup> for studying group dynamics or those used by Carl Rogers and his co-workers<sup>7</sup> for analyzing the processes of psychotherapy. We also considered a shorthand way of recording interactions based on the one described by French,<sup>8</sup> in which categories and rating scales were formulated with respect to the psychiatrist's intentions and acts, the patients' roles and attitudes, group orientation, personal involvement, and the frequency and length of speeches. We found that observers could be trained to use these with a high degree of reliability and that statistics could be accumulated with reference to such categories, but standard categories and statistics both proved unsuited to our purpose, as they could not be used to evaluate the processes of therapy. Our knowledge was not sufficient to set up categories in advance that would give us insight into these processes, and we felt that fixed series of categories into which observations must fit are likely to blind the observer to other phenomena. Furthermore, statistics showing what the psychiatrist does or says or how the patients react are of little importance compared with what each says or does in relation to a particular circumstance

or in a certain setting. In other words, a purely statistical event does not help one understand a dynamic interaction.

Above all, it seemed to us that categorizing units of behavior without reference to the settings in which they occurred would not lead to an understanding of the *meaning* of the behavior, which after all was essential if we were to attempt to understand what was going on therapeutically. It was of the utmost importance for us to study not only what a patient said or did, but the feelings associated with it, the thoughts or attitude he was trying to express in relation to it (sometimes without being aware of it himself), and the context in which it was expressed.

Since the same behavior can represent different attitudes, the meaning of the behavior can be determined only by study of the total situation.<sup>9</sup> Let us suppose, for example, that Patient A shakes his fist at Patient B and curses him. Observers would agree without hesitation that this behavior should be categorized as hostility. But is Patient A displaying anger at Patient B because he is jealous of B's relation to the doctor, because B reminds him of his hated father, or because he is afraid of B and is trying to hide it? Is he perhaps really angry at the doctor, and displacing his anger on B as a safer object for it? Or is he strongly attracted to B, frightened by this attraction, and blustering to hide this feeling from himself and others? Clearly, proper psychiatric handling of A's attack would depend on the answer.

Conversely, the same attitude may be expressed in quite different ways. Contempt, for example, may be shown directly, or it may be indirectly but effectively conveyed by being overly considerate and sweetly acceptant. If these attitudes were classified only by the observed behavior, the first would be classified as contempt, and the second as acceptance. The latter attitude might mean to the recipient that he was so fragile that he had to be humored, or that his opinion was too insignificant to be taken seriously. Anger would then be as appropriate a response to the apparently acceptant attitude as to the openly contemptuous one.

<sup>9</sup>Ruth Benedict<sup>9</sup> expresses a similar point of view from a different discipline. She shows how the effect of swaddling an infant depends on meanings so communicated by the mother to the child—different meanings being conveyed in different cultures.

Attempts to categorize the psychiatrist's attitudes or interventions without regard to the situations in which they occur would also give incomplete, inaccurate, or meaningless data. For example, at a certain point he may call attention to the feelings group members appear to have toward each other. This may be followed by a spurt of therapeutic progress, or it may paralyze activity. To understand its effect we must know what his words convey to the patients at the moment. This cannot be discovered by tabulating the number of times such an intervention occurs; it is necessary to understand the elements of the situation of which each intervention is a part. These elements include the psychiatrist's way of speaking as well as the appropriateness of his remark.

We therefore decided not to attempt to categorize behavior and attitudes, but to base our study on a simple narrative report of each group meeting, which we called the running account. This was supplemented by a summary of the discussion which took place between the doctor and observer after the meeting.

### *Note on Terminology*

In describing the processes of therapy, we used the term *dynamics* in reference to individual patients as well as to the group. The term *group dynamics*, or *process*, included all the interacting forces between patients and between doctor and patients—whether transient or persistent and whether based on transference or reality factors. These might change in a number of directions concurrently (for example, a patient's show of hostility might increase as he became more and more aware of other patients and of his responsibility toward the group). The moods and activities of a group were sometimes referred to as its *dynamic properties* in contradistinction to its *structural properties*. These structural dynamics may be transient or may become habits of group functioning—that is, tacitly accepted or tabooed topics or behavior.

We used *psychodynamics* as a general term in referring to those aspects of the individual patient which had to be considered in order to understand his reactions under a particular set of circumstances. This included specific conflicts and emotional states which might be



activated by specific situations (e.g., conflicts about a parent which were brought out by the attitudes of group members); habitual modes of reacting, such as timidity and aggressiveness; structural personality attributes, such as rigidity, dissociative capacity, and so on. We used the word *content* to refer to patients' accounts of recent and remote experiences, fantasies, and dreams. A patient's behavior in a group is the result of the interaction between his psychodynamics and the group's dynamics, and all activity—whether individual or group—of course involves both content and process, implicitly or explicitly manifested.

### *The Running Account of the Meeting\**

The running account was written by the observer, whose regular attendance enabled him to become familiar with the behavior patterns of the individual patients, to follow the development of patterns of relationship within the group, and to obtain a clear perception of the doctor's attitudes and techniques.

The running account was an eye-witness narrative of the activity taking place in the group; it was checked against the wire recording when questions of interpretation arose. It included the major verbal and non-verbal interactions between members and between members and doctor. The observer made free use of verbatim quotations but also aimed to record the relevant non-verbal gestures and activities—such as laughter, restlessness, and other expressions of emotion. In short, he tried to supply the data from which relationship might be inferred.

Since the observer obviously could not write a complete account of the meeting, he selected what seemed to be therapeutically significant. He tried to concentrate on the doctor's activities, marked changes in the patients' behavior, persisting attitudes of individuals, and interactions between them. This choice was constantly modified by increasing knowledge of the dynamics of group therapy and by the observer's and the doctor's increasing knowledge of the group. When we compiled these records sequentially, we had a fairly complete picture of

\*Major contributors: Helen T. Nash and Morris B. Parloff.

the developmental aspects of the group and of such changes in the patients as could be noted by direct observation.

The problem of subjectivity was inherent in this method. At times the observer's reactions served him as an indication of the feelings of the group, but he tried to discipline himself to catch his own emotional reactions in order to minimize distortion. Our studies on the accuracy and completeness of the observations (see Appendix B) indicated that the observers put down about half of what was recorded on the machine. Only about 1 per cent of what they did get was grossly distorted. It therefore seems safe to say that their selectivity did not adversely affect their accuracy. We were not able to evaluate the relative significance of what was included and omitted. Our findings, however, are evidence of the importance of what the observers reported.

*The importance of inferences.* As the observer watched the events of the group session unfold, inferences as to the interrelationship and meaning of what was transpiring occurred to him. In a column adjacent to that in which he entered his observations, he entered certain inferences which he believed to be useful. Observations and inferences were given corresponding numbers. The basic data were corroborated and elaborated in discussions with the doctor after the meeting and the inferences were checked with him after final formulation.

The term *inference* as used in this study refers to the research worker's subjective interpretations of observational data. In the early stages of the project the term was used in reference to interpretations which the observers made on apparently significant acts and words. Later it was broadened to include interpretations of seemingly related patterns or sequences of events in the setting of the total situation. Only those situations were abstracted in which cause and effect were comparatively clear.

Although each worker's interpretations were naturally influenced by his orientation and experience, considerable agreement on inferences was found among different reviewers of the record. When limiting effects appeared to result from personal bias, they were dealt with in informal discussions and in seminars. But since preconceptions are necessary to the arrangement of specific events in a meaningful fashion,

without inferences there could have been no selection or ordering of the data.<sup>10</sup> From the standpoint of therapy, the doctors found that the making and discussion of inferences gave them a better understanding of the complex situation with which they were dealing and thus helped to allay their anxieties.

The researchers used inferences extensively and imaginatively, but ultimately tested their validity by the following criteria: (a) no inferences were incorporated into situation or theme analyses unless concurred in by the observer and the doctor in charge of the group and usually also by a senior psychiatrist; (b) all inferences were checked by evidence provided by repetition and predictive value.

For purposes of clarifying our use of inferences we can differentiate three types:

1. Specific elements from the total complex of observable verbal and non-verbal acts were placed in a tentative cause and effect relationship. This type of inference might be based on (a) direct observation of the immediate cause and apparent effect or (b) indirect knowledge of apparent cause (i.e., events reported to have occurred outside the meeting) and direct observation of apparent effect. Example of (a): During a meeting of a hospital group the doctor interrupted a silence to comment that Patient A, who had been mute, was the group leader and Patient B, who was also mute, was his second in command. Shortly thereafter B left his usual chair and seated himself for the first time next to A. An inference of the first type would state that B was responding to the doctor's remarks. This kind of inference does not attempt to describe anything further concerning the relationship of these events. Example of (b): A hospitalized patient appeared extremely agitated at the opening of a meeting. It was subsequently learned that his wife had visited him the previous afternoon. The following facts were considered prior to making an inference: (1) at the last group meeting, before the visit, the patient had appeared calm; (2) a review of the nurse's notes revealed that he had become overactive immediately after his wife's visit and had required sedation. The inference was then made that the patient was reacting to this visit.
2. Attempts were made to explain cause and effect relationship in

terms of the patient's dynamics and the group situation. This type of inference sought to explain the patient's behavior in terms which would be useful for therapy and, being based on the first type of inference, was less direct. For example, the first case cited above might be interpreted as a demonstration of affection for the doctor or as an acceptance of him as an authority figure. The choice would depend on the understanding of the total situation.

3. Attempts were made to fit events into a category, concept, or theory. Thus, in terms of the first example, if B's behavior toward A and the group followed a consistent pattern over a period of time, then one might infer that B had assumed a particular role; that is, his behavior could be subsumed under the general concept of role-playing. Hypotheses were also made in terms of our own or other workers' theories, as when a hospitalized schizophrenic made repeated reference to having had his eggs stolen and this was interpreted as possible evidence of a persisting infantile anxiety concerning castration. Although inferences of this type helped to stimulate our thinking, they were not usually included in the records without supporting data. The sharp distinction made between observations and inferences in the running account kept the observer aware of the differences between them and tended to heighten the objectivity of the account.

### *The Summary of the Meeting\**

A summary of each meeting was prepared by the observer, on the basis of the running account and on one or two discussions with the doctor. It singled out the points which the doctor and the observer agreed should be emphasized. It contained relevant references to previous meetings and goals and predictions for future meetings. The data included in the summary were keyed by numbers so that the reader could refer to that part of the running account from which

\*Early in the project we thought that periodic summaries of every 10 to 25 meetings would bring out long-term changes in the patterns of groups and individual patients. These were organized around hypotheses of what we thought would be valuable and involved an enormous amount of data. We finally gave the plan up, since our ideas changed with experience and we had to return to the original data instead of the summaries. The problem of how best to summarize long-term phenomena remains an open one.



the data and inferences were derived. We used T (therapist\*) and O (observer) to denote the person making the inference on the rare occasions when they disagreed. Summaries were organized under the following headings:

*The doctor's reactions and goals.* This section included the doctor's impressions of the meeting, his own feelings during it, his therapeutic goals for the session just completed and the degree of success in achieving them, his goals for the next session and his plans for carrying them out.

*Group dynamics.* This section included over-all impressions of the meeting, interactions between patients, and phenomena of the group as a whole, with emphasis on: changes in activities, themes, and relationships since the previous meeting; persisting relationships; observations and inferences concerning the effects of the absence of old members, the entrance of new members, and any other aspects of the mechanics of the group; and observations and inferences concerning the development of the group, its mores, and structure.

*The doctor's interventions.* This section summarized particularly significant interventions by the doctor and their effects.

*Behavior and psychodynamics of individual patients.* This section included a summary of the behavior and contributions of each patient in the group. Attention was called to the effect of private sessions on the patient's activities in the group and to any themes or important issues concerning him that showed changes or indicated persistence of pathological patterns.

### *The Situation Analysis†*

In analyzing the running accounts, instead of looking for data to fit into categories, we looked for events which seemed to have positive or negative therapeutic significance and described them in relation to the events which preceded and followed them. This led to the development of a method of analyzing situations in terms of various aspects of therapy which we called the situation analysis. By definition a

\*Since all the therapists in our project were doctors of medicine, and since the patients invariably referred to the therapist as "the doctor," we have used the latter term throughout the body of this report.

†Major contributors: David Rosenthal and Edith Varon.

*situation* included a series of events showing cause and effect relationship described with reference to the setting in which they occurred. Such a situation formed a kind of pattern, and some situations, we found, apparently formed similar patterns, which, when systematically compared, added to our understanding of treatment. In selecting situations for study, we chose problems which presented themselves during therapy and which we thought might be clarified by analysis.\* A few examples will illustrate on what we focused.

During the first meeting of one group Patient A consistently interrupted when other patients were talking but did not use the time constructively for himself. The doctor decided to handle him by ignoring his next remark; other patients followed the doctor's lead. By the end of the meeting there was a marked change in A's behavior; he recognized his own anxiety and purposefully discussed similar behavior in his everyday life. From the therapeutic viewpoint we wanted to know how A had changed and what had brought the change about. Did he change because he was ignored? What was there about his psychodynamics and his relations with the doctor and with the other members of the group that made him react as he did?

In a second group Patient B consistently asked for advice, only to reject it when it was given. Patient C grew increasingly tense until the doctor mentioned his tension as well as his inability to get the floor. C then brought out the similarities between his mother and B; concomitantly he relaxed. What was the connection between the

\*Sullivan<sup>11</sup> points out that in conceptualizing human behavior we must think in terms not of individuals but of situations: "When we speak of impulse to such and such action . . . or use any of these words which sound as if you, a unit, have these things in you and as if they can be studied by and for themselves, we are talking . . . about something which is observably manifested as action in a situation. The situation is . . . you and someone else integrated in a particular fashion. . . . The situation is integrated in such a manner as to resolve itself after a change that is satisfactory or satisfaction-giving or tributary to security. . . . [The] situation is so integrated that what action there is in it can move to the discharge or resolution of some dynamic component in each of the people."

The sociologists Thomas and Znaniecki<sup>12</sup> have developed a similar concept. They regarded every concrete activity as the solution of a situation, defined as "the set of values and attitudes with which the individual or the group has to deal." They also stressed that the person's own definition of the situation, from which his activity arises, is determined not by the objective conditions *per se*, but by how he perceives them as a result of his pre-existing attitudes. Their "situation" is roughly equivalent to what we have termed the "setting," and their "concrete activity" includes our "event" and "effects."

In a brief but stimulating comment French<sup>13</sup> points out that psychotherapy is not a unitary process, but "a long series of many clinical experiments—the results of each experiment must be studied separately."

group situation and C's increasing tension? Why did he react as he did to the doctor's intervention, and how did his reaction affect other members of the group?

In a third group Patient D talked extensively but obscurely of his lurid dreams, without achieving any insight or relief. Eventually a fellow patient hinted that D should stop talking. When the doctor asked D to tell the other members what he thought of the group (something D had brought up in an individual session), D very quickly and lucidly described the similarity between his feelings toward the group and his feelings toward his family. His emotional relief was obvious, and he voluntarily gave up the floor to others. What were his relations with the doctor and with the group, as a result of which he first spoke obscurely; what brought about the change to a clear and useful analysis of his feelings; and how did this affect him and the other patients?

Sooner or later in every group we observed there appeared a phenomenon that we called *rallying around a topic*, because, instead of talking about the problem of a particular member, patients talked about a topic of interest to all. On one occasion, for example, the doctor rebuffed a patient who wanted to talk about the death of a former member. There was a tense silence, then the patients discussed "silence" versus "talking in the group"; subsequently, they went back to their personal problems. In analyzing the situation in which this rally occurred we asked why the subject of the patient's death had been introduced in the first place, why the doctor rejected it, and how the discussion of silence came about and what were its effects.

The examples cited above illustrate the type of situation which is most readily selected for analysis. Either the doctor or a patient says something which produces a marked effect, and subsequent events are thought to be its consequences. Such a situation is easily recognized by the psychiatrist and the trained observer, and the experience is similar to the figure-ground phenomena of *Gestalt* psychology. Certain events begin to stand out more sharply, while others recede into the background. The observer becomes aware that "something is happening," then senses a kind of pattern, and in the most clear-cut situations feels something akin to closure. Although the beginning and the end of the situation may not be sharply defined, and the exact nature of the situation is not immediately identified, the event is experienced by the observer as something unitary.

The identification of a significant situation is often aided by a change in the group's tension. It may be that the tension gradually rises, as two members argue, while others listen uneasily. Finally, either the doctor or one of the patients has a feeling that something should be done and says or does something which eases the tension. Simultaneously with this decrease, there is an observable shift in the pattern of relationships.

The situation analysis was devised to provide a means of ordering the vast amount of material at hand, so that cause and effect relationships would emerge more easily. It selected those elements in the data that were essential to an understanding of the events being analyzed, organizing them to show the motivational forces at work in the situation. Organizing the data presented both the most crucial and the most difficult problem because, in order to give them meaning, it was necessary to simplify them but at the same time to keep in mind the *Gestalt*, the complex pattern of the group, formed by the interaction between the patients and the doctor. The feelings, experiences, and attitudes which each patient brings to the group affect not only his own behavior in the group situation but that of the other members. The doctor's behavior is also determined by his personal characteristics, modified by his training and experience. As the group continues to meet, it acquires a history which includes problems with which it has been concerned, the direction in which it has been moving, and persisting relationship among the patients. The history persists as an influence on present events. The analysis of the situation aims to describe the pattern of these forces.

The primary aspects of group functioning to be considered in any analysis were the dynamics and mood of the group, the relationships of patients with the doctor, the psychodynamics of individual patients, and the immediate aims and techniques of the doctor. What patients talked about—the content of the meeting—was not considered or described independently of these aspects but was included as an integral part of them: that is, content was the major vehicle through which they were expressed.

A systematic study of a situation would include an examination of all aspects for their possible bearing on what occurred. In actual



practice, it was necessary to be more selective and to include only those without which this situation could not have occurred. For example, in Situation Analysis 39, in which Coombs described the group as his family, there were many aspects of his relationships with individual group members which could have been included to explain how each man came to represent one of his siblings (see Table 1). To have done this, however, would only have confused the issue.

It was as important to eliminate from the write-up of the situation anything which was not significant for a particular analysis as it was to include what was clearly related, for the inclusion of extraneous material in the analysis confuses the search for causal relationships. We omitted all observations which seemed irrelevant, such as references to silent members who gave no indication of how they were involved in what was going on. Or, the mood of the group might not be mentioned, unless it appeared to be involved in the event, as, for example, when the hostility of the group seemed to enable a patient, who was usually friendly, to express his anger at another patient.

Such selectivity necessarily distorted to some extent the picture of what happened and omitted subtle influences. The checks used to detect incorrect interpretations are discussed below.

### *The Form of the Situation Analysis*

The analysis was written so as to bring out interrelationships of the setting, the event, and the effects. This division was guided in each case by the point that was being illustrated. The same occurrence might be part of the setting in one analysis, the event in another, and an effect in a third. The demarcation between setting, event, and effects varied in sharpness in different analyses. The writer tried to divide the material in the way which seemed to make its point most clearly. As a further aid to clarification, the longer subdivisions of an analysis were headed by a brief abstract of their contents. The parts of the analysis were as follows:

1. The setting in which the event occurred
2. The precipitating event (optional). If used, this represented the transition between the setting and the event
3. The event

## 4. The effects

## 5. The discussion (optional)

## 6. Tentative deductions (optional)

THE SETTING gave those aspects of the background which appear to be significantly related to the focal events of the situation. It was usually easy to recognize the event and effects in a situation; in fact, this was how most situations were discovered. The causes of the event, however, were likely to be obscure and to involve many aspects of group activity. Since we were seeking causal relationships, it was essential that all possible causes be looked for. This was done, insofar as possible, through detailed consideration of all aspects of the group's activity before selecting and organizing the material to be included. It was especially important to write the setting as simply and clearly as possible, including details related to the event but omitting extraneous details which would only confuse the issue.

We selected for description the aspects of the background directly related to the central event of the situation. For example, if the event had to do with the expression of hate, then under group dynamics we would describe the group's attitudes toward the expression of hate, in terms of favoring, rejecting, or being in conflict about it. When group members differed we described these differences.

Some situations could not be understood without taking into account a large segment of the group's history. Enough history was included to indicate the directions of any changes in group functioning relevant to the situation. In early meetings certain events might have been followed by only partial resolution of the tensions involved. Then new situations might reactivate them, leading to a dramatic rise or fall in tensions, inexplicable on the basis of the events of the current meeting. To understand such a situation, it was necessary to study the records of meetings that had taken place weeks or months in the past. For example, in Meeting 38 of one group, several patients expressed their annoyance with another because of his intellectuality. In Meeting 39 still another patient attacked him for his anti-Semitic attitude. The tensions engendered by this hostility were not resolved until Meeting 48, in which he was again attacked for his aloofness. There was a crucial change in his attitude after this meeting. The

climax that was reached could be understood only in the light of the cumulative effect of the earlier events.

In clear-cut situations there was usually an observable rise or fall in the tension of the group, which changed after the focal event. A description of changes in tension was sometimes necessary in order to clarify the relation between the setting and the event.

If it was uncertain whether the material in the setting was relevant to a given situation, it was included with the thought that analyses of similar situations might give clues to the relationship.

**THE PRECIPITATING EVENT:** Sometimes one particular episode seemed to touch off the event. We singled this out as the precipitating event. A frequently occurring example was the tendency of one patient to behave in a manner to which another was sensitive. Thus, Bridges' advice-giving, which regularly made Minor tense, and Trippitt's arrogance, which habitually caused Coombs to attack him, were regarded as precipitating events (see Table 1). We sometimes also classed as precipitating events transitional occurrences which could equally well have been included as part of the setting or part of the event.

**THE EVENT** was the occurrence which was accompanied or immediately followed by a change in tension, behavior, or attitude. It might be very brief or last most of the meeting. On one occasion a brief comment from the doctor stimulated Minor to examine his behavior and feelings, with consequent increased insight (see Table 1). On another occasion the overbearing and aggressive behavior of a fellow patient (part of the setting) produced a general attack on him which lasted half an hour (event) and which in turn had the effect of making him less overbearing in subsequent meetings. In the latter case the event was a unit; it lasted so long because the entire group was focused on the same patient to the same end. It should be emphasized that ways in which the patients perceived or reacted to the event (that is, its effect) were partly determined by the setting in which it occurred. A given episode might be ignored, might block group activity, or might facilitate it—depending on the setting.

**THE EFFECTS:** Developments produced by the event in its setting, including therapeutic progress made by the patients, were discussed under this head. The effects might appear as changes in the behavior

of one or more members of the group or as changes in the relationships among patients or in group mores and might extend through several meetings. The effects of one situation might provide part of the setting for future situations. In Table 1 changes can be seen in Minor, in his relationship to Bridges, and in the history of the group—recognition that tension may come from using a group member as a surrogate for a close relative.

THE DISCUSSION: An explanatory section was included when it seemed necessary to point out why certain factors were thought to be *determinants* (see below). This discussion facilitated comparison with other situation analyses and was also used to state implications for therapy.

THE TENTATIVE DEDUCTIONS consisted of brief formulations of the essential relationships of the setting, the events, and the effects. We termed these relationships *determinants*. They were couched insofar as possible in terms which permitted comparison with other situation analyses. The validity of the tentative deductions was tested by such comparison.

### *Selection of Situations for Analysis*

Two principles guided the choice of situations for analysis. The first was clarity and significance, illustrated by the examples at the opening of the chapter. These were readily identified as situations in which a noteworthy change had occurred and which were significant for the understanding of the processes of therapy. The second was relevance to particular problems engaging our attention. When some situations called attention to a certain therapeutic issue we would search for other situations which might throw further light on the issue, and on our understanding of the determinants of the situation. These might be failures as well as successes in techniques.

### *Validation of Situation Analyses*

The problem of validating situation analyses lay in finding ways of increasing the reliability of our tentative deductions. We had to be reasonably sure that relationships actually existed and were not figments of the observer's imagination. Obviously therapeutic situations could not be set up experimentally. We had to rely on a number of



expedients. The probability that the relationship described conformed to the facts was heightened by obtaining confirmation from the doctor.

No analysis was used in the body of our work unless the doctor and the observer finally agreed on what had happened in the situation. If they could not come to an immediate agreement, the analysis was put aside in the hope that subsequent events would show the correct interpretation. Sometimes further study actually produced an agreement. In such cases we reasoned that the possibility of error was sufficiently reduced to permit use of the analysis.

If the observer and the doctor agreed, further consensus might be obtained from other members of the research team. In practice many situation analyses were modified after a check of the running account by another worker.

The next step in validation was to look for other situations, particularly in other groups which were comparable. It may be seriously questioned whether this was ever possible, since each analysis differed from every other one. The experiences of the research team showed that some had enough points in common to make comparison possible. For instance, in two groups run by different therapists each had a member who was superior and aloof and acted as though he had no emotional problems; in both cases this member became the butt of the other members' hostility. If two situation analyses were apparently comparable as to setting and event but had different effects, we would review the original data for misinterpretations or omissions. If two or more situations had similar effects, although the settings appeared to differ, we examined the settings to see if they had points in common. By such reviews we increased the accuracy of our deductions.

Table 1 demonstrates the way in which the comparative tables of Chapters VII-IX, XI, and XII were made.<sup>o</sup> As can be seen from a study of the two right-hand columns, points of similarity as well as difference appeared in Situation Analyses 39 and 26. In each case the patients wanted to please the doctor, and the doctor habitually directed the patients to the examination of attitudes they displayed

<sup>o</sup>Throughout the series the number of categories in the left-hand column was varied in order to facilitate comparison of different cases, but the main categories—setting, event, and effects—were uniformly retained.

TABLE 1. Comparison of Situation Analyses 39 and 26

	<div> <div> <i>Situation Analysis 39</i>  DOCTOR N's GROUP I, Meeting 72 </div> <div> <i>Situation Analysis 26</i>  DOCTOR N's GROUP III, Meeting 5 </div> </div>	
SETTING		
<i>Group dynamics</i>	<p>Members expressed hostility freely with expectation of making therapeutic progress through examination of feelings.</p> <p>Overtly hostile relationships predominated.</p>	<p>Members could not yet easily express feelings but needed to talk to each other and were able to.</p> <p>There was little recognition of the underlying hostility. They politely maneuvered for status.</p>
<i>Relationship to doctor</i>	<p>Coombs had been openly hostile to Trippitt, as had all but one of others.</p> <p>Patients were anxious to please doctor.</p> <p>Doctor encouraged patients to examine their own attitudes.</p> <p>Patients were comfortable with doctor.</p> <p>Negative feelings for doctor had been expressed.</p>	<p>Minor had been covertly hostile to Bridges, as were others in this meeting.</p> <p>Same as S. A. 39.</p> <p>Same as S. A. 39.</p> <p>Patients were less comfortable with doctor.</p> <p>No negative feelings for doctor had been expressed.</p> <p>Patients sought advice and direction from doctor.</p> <p>Minor was neurotic who compulsively complied with doctor.</p>
<i>Psychodynamics</i>	<p>Coombs was ambulatory schizophrenic who compulsively complied with doctor.</p> <p>He had displaced his hostile feelings toward his family upon group and especially upon Trippitt, whom he had previously used as surrogate for younger brother. Hostility arose before current meeting.</p>	<p>Minor had displaced upon Bridges annoyance he felt with his mother for her refusal to face reality, without recognizing it as displacement. Hostility rose during this meeting.</p>

## PRECIPITATING EVENT

Coombs expressed anger originating outside group, in lurid, confused way. Focusing on this failed to clarify its meaning.

Trippitt indicated desire to present problem of his own because Coombs wasn't getting anywhere.

## EVENT

Doctor, who knew from individual therapy of Coombs' displaced feeling and planned to bring it up in the group, asked Coombs to tell how he felt group was his family.

Coombs told of his feeling that group represented his family and that they were going to cast him out.

## EFFECTS

Coombs' tension was released when he brought out feeling about group. He saw that he secretly wanted the group to cast him out. This was his way of punishing them, since he felt that they could not get along without him. He had same feeling toward his family.

After Coombs finished, group went on to something unrelated to his problem.

Minor became increasingly tense as Bridges kept on inviting advice and rejecting it. Doctor pointed out group's fear of expressing feelings, Minor's seeming inability to gain a hearing, and his tension.

Minor said that he realized he had been reacting to Bridges as though Bridges were his mother. Minor's mother, like Bridges, lived in dream world, and Minor told Bridges, as he told her, to face reality.

Doctor and others discussed therapeutic value of self-examination, approving Minor's insight.

Minor relaxed and realized in expediency of advising others and assuming responsibility for them. He mentioned recent insight that he was not really responsible for his mother or able to change her. He observed that he had likewise been trying to straighten out Bridges but might not be able to because he hadn't the answer to Bridges' problem.

Other patients were then able to examine their feelings, such as fears of insanity (as opposed to advice-seeking and -giving which had preceded this event).

in the group. In each case the central patient was compulsively compliant and was supported by the doctor in the expression of his feelings—Coombs directly and Minor indirectly, when the doctor commented that Minor had difficulty in getting a hearing. In each case the situation revolved around the displacement of hostility from the family to the group, or from a member of the family to a member of the group. However, in Situation Analysis 39 the patients were having their seventy-second meeting, were comfortable with the doctor, and could express their anger openly, whereas in Situation Analysis 26 the group was in its fifth meeting, was less comfortable with the doctor, and was incapable of direct expression of hostility. Moreover, Coombs (the central patient in Situation Analysis 39) was a borderline schizophrenic who completely distorted the real situation in the group, whereas Minor (the lead patient in Situation Analysis 26) was a neurotic who did not distort the actual situation. Although Coombs' hostility was something with which the group was familiar, his feeling was not provoked by interactions in the group, and the other members felt relatively detached from him. This was apparent from the way in which they failed to react emotionally when he presented a feeling about them based on a complete distortion of the group situation. When Coombs' tension was eased, the group went on to other problems unaffected by the resolution of his problem. On the other hand, Minor's feelings were aroused by interactions in the group and were in accord with those of other members. His desire to change Bridges, a displacement of desire to change his mother, was in keeping with the prevailing need of his fellow patients to do something to one another. Their feelings, like his, were not clearly defined, and they had difficulty in expressing them. The examination of Minor's feelings caused the others to examine their own feelings instead of giving advice as they had been doing up to this point.

Such situations raised the possibility that examination of a displaced feeling must fit into the mood of the group as a whole if it is to lead to insight and relaxation. (This is an example of what we called tentative deductions.)

The comparison that follows illustrates how our knowledge of determinants was refined by comparing situations. The determinants



arrived at in our analysis of one situation guided us in studying other situations. These in turn led to modification of the original determinants and to discovery of new ones. Obviously, the larger the number of situations compared, the greater the validity of the deductions finally reached. The determinants arrived at in the original analyses were:

*Situation Analysis 39*

1. Group dynamics which encourage the expression of hostility and self-examination.
2. Coombs' compliance in examining his feeling when the doctor tells him to.
3. The doctor's telling Coombs to describe his feelings toward the group.

*Situation Analysis 26*

1. Group dynamics characterized by the need and ability of patients to keep in verbal contact with one another.
2. An analogy between the group situation and Minor's home situations in respect to:
  - (a) Feelings of tension, and
  - (b) Advice-giving and conflicting attitudes toward self-examination.
3. Analogy between Bridges' behavior and that of Minor's mother.
4. The doctor's:
  - (a) Calling attention to what was going on in the group (process) and feelings.
  - (b) Approval of self-examination.

The determinants arrived at by comparison of the situations were:

1. *Not modified*: The doctor's intervention.
2. *Modified*: The group dynamics in the two situations appeared to be different but further study showed that a determinant common to both was the harmony between the feeling of the individual and the atmosphere of the group. Compulsive compliance toward the doctor proved to be characteristic of both the central patients, although it was not originally noticed as a determinant in Situation Analysis 26.
3. *New determinant*: A comparison of the two situations shows that in both cases the central patient's feeling was displaced upon a

patient who had previously been the target of hostility from other members. This was formerly not considered a determinant in either situation but is now included as a possible determinant.

**4. Discarded as determinant:** None.

These deductions, of course, would be subject to further modification or verification through comparison with other analogous situations.

***Problems in Classifying Situation Analyses***

It was thought at first that we could devise a scheme *a priori* by means of which situation analyses could be classified and compared. Such a scheme was drawn up by selecting the chief variables in the group situation and assuming that any one of them might influence the situations under study. The situation analyses, it was then thought, would bring out the relevance of each of these variables to treatment. The variables were: the doctor, the psychodynamics of individual patients, the content brought out by individual patients, the composition of the group, the developmental stage reached by the group, the dynamic properties and structural properties of the group, the moods, mores, and goals of the group, the potency (i.e., relative importance of the group to the members), the effect of the observer, and extra-therapeutic factors. All these variables were so complicated that we were not able to make the analysis necessary to sort out the ways in which they influenced the processes of therapy. Our classification scheme broke down because it was not detailed enough to take into account the modifications of each variable by the others.

We tried various other ways of systematically covering all phases of group therapy but without success. Finally, on the basis of experience we simply chose problems in therapy which were outstanding and on which we had data. We then collected situations that bore on these problems. It may be that grouping of situations by the therapeutic problems involved in them will remain the only possible way of organizing them.

***Analysis of Long-Term Processes***

In addition, we recognized that there were processes of therapy which covered long periods of time, the continuity of which could not be

shown by means of situation analyses. These processes were distinguished by a characteristic pattern, an example of which is given in Chapter vi (pp. 144 ff.). Because of lack of time and the methodological problem involved, our material was not studied to any great extent in this way.

As we analyzed our material in terms of situations and long-term processes we found that the experience clarified our thinking about therapy. It pointed up and increased the value of the seminar discussions, and it gave us ways of thinking about what was going on during treatment that sharpened our insight and improved techniques as time went on.

## CHAPTER III

### *General Description of the Research with Clinic Patients*

---

APPLICANTS for treatment at the Mental Hygiene Clinic were Armed Forces personnel who had been referred by private physicians or by rating physicians in the Veterans Administration or other agencies from whom they had sought help. They were screened by a physician for suitability for the type of treatment offered by the clinic and by a social worker to determine eligibility, and then were assigned to psychiatrists by the chief of the clinic. Each patient selected for group therapy was also interviewed and tested by a social worker and a psychologist who were members of our research team.

Originally, the psychiatrists participating in the study composed their groups from among patients they were treating individually, solely on the basis of suitability for group therapy. Later, one psychiatrist took consecutive patients into groups directly after their preliminary screening, then also tried to compose a group in terms of what he had learned.

It seemed best not to make any systematic attempt to compose groups at the start. The research program had to be conducted in such a way as not to interfere with the normal functioning of the clinic. This precluded, for example, shifting patients from one doctor to another or permitting a waiting list to accumulate from which selection could be made. We were further handicapped by the fact that at first only one of the psychiatrists who led groups had had experience with group therapy and therefore experience from which to develop criteria for choosing patients other than those used in selecting patients for individual treatment. We also wished to avoid prejudging the issue,



especially since statements in the literature about composition of groups left us unconvinced.

The same psychiatrist stayed with his group throughout the study, using a substitute if he had to miss a session. In keeping with the exploratory nature of the project, whether groups were to be "open" or "closed" was left up to the doctors. The longer the groups ran, the less the tendency was to take in newcomers, so that eventually all the groups were closed. Most of the patients received regular individual therapy concomitant with group therapy. All the groups met once a week for an hour and a half, except for one group not receiving concomitant individual therapy, which met twice a week for a few months.

### THE SURVEY OF THE RESEARCH POPULATION

Since the only patients admitted to the clinic were those whose illnesses had been caused or aggravated by service in the Armed Forces, our experimental population had certain limitations with respect to clinical diagnoses, duration of illness, intellectual and educational level, age, and cultural factors. Any conclusions on suitability for group therapy or on composition of groups are, of course, applicable only within the ranges of our project. A breakdown of the clinical diagnoses by type of treatment is given below.

	Group therapy	Group and individual therapy	Total
Patients treated	24	100	124
Psychoneurotic reactions	20	80	100
Character and behavior disorders	4	11	15
Psychoses		9	9

NOTE: The categories are those used by the Veterans Administration (TB Med.-10 A-78).

There were differences in regard to the frequency with which our doctors used certain sub-categories in their diagnoses, but this did not necessarily reflect actual differences in their patients.\* Hence we made no attempt to use sub-categories in our tabulation. Our cases

\*In a recent study three well-trained psychiatrists diagnosing patients as carefully as possible on the basis of a simultaneous examination agreed even as to the major diagnostic category (e.g., psychosis, neurosis, mental deficiency) in only about 45 per cent of the cases. Agreement dropped to 20 per cent with respect to sub-categories.<sup>1</sup>

included no examples of conditions, such as mental deficiency, which would have prevented acceptance by the Armed Forces, or of conditions which, had they existed uncomplicated by neurosis, would have led to an administrative discharge on moral grounds.

Of the 6 patients who were chronic alcoholics, 5 were diagnosed as having an accompanying psychoneurosis, and 1 a character disorder. Since it was the latter conditions which made them eligible for treatment, they were included in these categories. One patient who was included in the psychoneurotic category also had suffered a brain wound, but his symptomatology appeared unrelated to his injury. Six patients were referred as psychosomatic\*; of these 2 had peptic ulcers, 1 eczema, 1 psoriasis, 1 asthma, and 1 hypertension. However, almost all the patients had some somatic complaints. The patients diagnosed as having character disorders received treatment because their conditions were considered to have been aggravated by service. In most cases the disorder was an immaturity reaction. One patient also had a mild type of epilepsy, which seemed unconnected with the problems for which he sought treatment. All but 1 of the psychotics were either borderline cases or in remission. Except that there were no psychotics or alcoholics among them, the patients receiving group treatment only did not differ significantly in regard to diagnosis from those receiving both group and individual treatment.

The great majority of the patients were chronic cases.† A crude measure of the minimal duration of their disorders is given by the number of months between discharge from military service and coming under observation by our staff. Actually, all the patients had been sick an indefinitely longer period, since their disabilities must have been acquired before discharge. For example, the 4 patients who had been out of the army less than 6 months before seeking treatment had been ill for at least 18 months before discharge. The median number of months between discharge from military service and joining one

\*Here classed as psychoneurotic.

†Owing to limitations of space we have omitted the basic figures from which the data concerning race and religion, length of military service, diagnoses and duration of illness, age and marital status, education and occupation were calculated. For our purposes the exact values were unimportant.

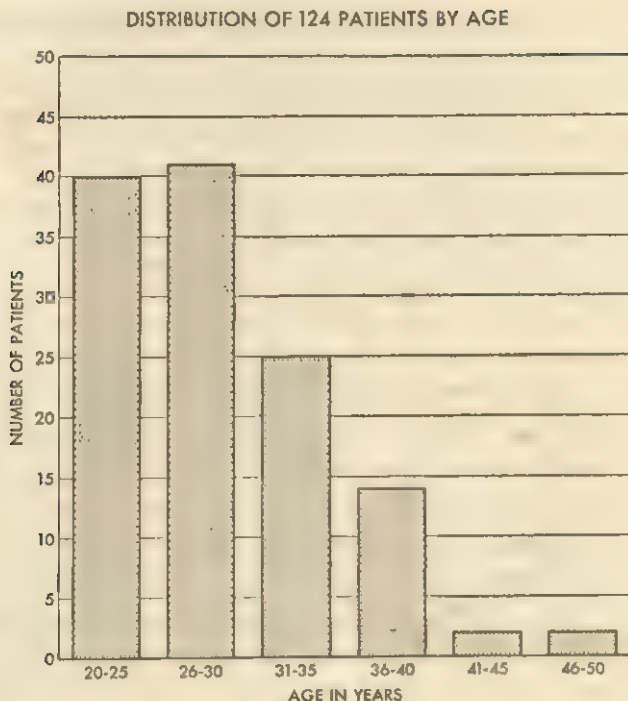


CHART 1

of our groups was 22 months, with a range of 0 to 66 months.

Eighty-two (66 per cent) of the patients were between the ages of 20 and 30. Only 4 (3 per cent) were over 40 and none were over 50 (see Chart 1). There was a relatively large proportion of single men—slightly over a third—while only 8 per cent were divorced or separated.

About 94 per cent had better than grade school education, and about 40 per cent were in or had completed college. The relatively high educational level of the patients may be partly explained by the fact that there was a university within two blocks of the clinic.

About 75 per cent of the patients had clerical positions or were students or professional men, and less than 10 per cent were unskilled laborers. This reflects the fact that practically the only big employer in the District of Columbia is the Government, and that at the time of this study many veterans were taking advantage of the G. I. Bill of Rights to improve their education.

About 60 per cent of the patients were Protestant, 25 per cent

Catholic, and the remainder Jewish. There were five Negroes; the rest were Caucasian.

The over-all picture of the size of our groups, the average attendance at each meeting, the number of meetings observed, and the periods of observation are indicated in Table 2. One hundred patients in 9 groups received individual as well as group treatment; 24 patients in 3 groups received group treatment only. It will be noted that, except in Dr. N's Groups III and IV, the average attendance was not more than half the total roster of a group—that is, the number of patients who attended at least one session. As appears in the survey of the patients who left groups (see Chapter IV), most of the patients who dropped out did so early; thus the averages tend to represent the number in attendance when the groups had become stabilized. Their smallness reflects the doctors' reluctance to take in new patients after a group had become established (see Chapter XII) and the fact that most of the patients felt more uneasy in a large group. It is probably not an accident that the best-attended groups were started by the doctor who had had the most experience. The total number of group meetings of which running accounts were made was 453. The largest number of meetings of any single group recorded by an observer was 101, the smallest number was 8 (average 41), and the periods of observation of the groups ranged from 2 to 19 months, with an average of 10. Five groups were observed for 11 months or more and 4 for 40 sessions or more.

Excluding preliminary individual interviews (from 1 to 4), each of the 24 patients who received group therapy without regular individual therapy attended an average of 28 group meetings and 1 individual session during the period of observation.\* After the initial interviews no patient had more than 5 individual sessions; 11 patients had no individual sessions. Each of the 100 patients who had both group and individual sessions was seen on an average of 19 times individually and 18 times in the group during the period of observation.†

\*Average number of group sessions per patient = Number of sessions of each group  $\times$  the average number of patients attending  $\div$  the total number of enrolled patients.

†Average number of individual sessions per patient = Sum of individual sessions attended  $\div$  the number of patients.



TABLE 2. Groups Observed at the Veterans Administration Mental Hygiene Clinic in Washington: Summary of Attendance and Duration of Treatment

<i>Designation of group</i>	<i>Total roster</i>	<i>Average no. attending each meeting</i>	<i>No. of meetings observed</i>	<i>No. of months under observation</i>
*Dr. N's Group II	15	5	98	16
*Dr. N's Group III	6	6	29	6
*Dr. N's Group IV	3	2	8	2
†Dr. K's Group	14	6	61	16
†Dr. L's Group	10	5	21	5
†Dr. N's Group I	13	6	101	19
†Dr. P's Group I	14	5	34	11
†Dr. P's Group II	7	4	10	3
†Dr. R's Group I	14	6	41	11
†Dr. R's Group II	7	3	9	6
†Dr. X's Group	14	5	26	7
†Dr. Z's Group	7	4	23	6
TOTAL	124	—	453	—
MEAN	11	5	41	10

\*Group treatment only.

†Group and individual treatment.

The great variation among the groups in the number of meetings observed resulted from the fact that some groups were terminated after only a few meetings. Since various members of a group progress therapeutically at different rates, only by accident would an entire group reach maximum benefit from psychotherapy simultaneously, and this did not occur in any of our groups. The usual reason for terminating a group was that the doctor left the clinic. This occurred in 8

groups during the course of study. The patients in 5 groups were given an opportunity to continue treatment in individual sessions with another doctor; 3 groups were taken over intact by another doctor.

Two groups were terminated because only a few members remained; these were transferred to another group led by the same doctor.

### CHARACTERISTICS OF INDIVIDUAL GROUPS

Summaries of certain characteristics of the members of each group follow. The patients in Dr. N's Group II and Group III received group treatment only. The patients in all the other groups received individual and group therapy.

#### *Dr. K's Group*

The roster was 14 patients. New members were introduced up to Meeting 21, at which the maximal attendance of 9 was reached. By Meeting 40 there were 5 patients and these were at Meeting 67 when observations stopped.

*Race and religion.* All patients were white, and with the exception of 2 Jews and 1 Catholic all were Protestants.

*Military service.* One had been in military service for 3½ months; the others had served for a year or more. Eight had been overseas, 4 of these in combat.

*Diagnosis and minimal duration of illness.* There were 5 schizoid personalities. The others were neurotics having obsessive reactions, anxiety reactions, conversion reactions or dissociation reactions. Two were stammerers, but were not in the group at the same time. Minimal duration of illness ranged from 14 to 44 months.

*Age and marital status.* Ages ranged from 23 to 38, with only 1 patient over 30. Seven were single, 6 were married, and 1 was divorced.

*Education and occupation.\** All patients had finished high school or trade school. All except 4 had done some college work. Two patients

\*In order to give an accurate picture of the various groups actual occupations are given in this section. In the descriptions of individual patients occupations have been changed for purposes of disguise.

were lawyers, and 1 was a machinist. The rest were white collar workers or students.

### *Dr. L's Group*

The roster was 10 patients. A maximal attendance of 8 was reached at Meetings 5 and 6. As patients left, they were not replaced. There were 6 in treatment when observation of this group ended at Meeting 22.

*Race and religion.* All patients were white, and except for 1 Jew and 2 Catholics all were Protestants.

*Military service.* All had been in military service for 2 years or more. Five had been overseas, and 4 had seen combat.

*Diagnosis and minimal duration of illness.* Four patients had schizoid personalities. The others were diagnosed as having conversion reactions, passive-aggressive reactions, and anxiety reactions. Minimal duration of illness ranged from 16 to 66 months.

*Age and marital status.* Ages ranged from 23 to 34 years, with 3 patients over 29. Nine were married, and one was single.

*Education and occupation.* All patients had had a minimum of 1½ years of high school. One had finished college, and 2 had finished law school as well, while 1 was currently completing college work. One patient was a plumber and 1 a cab driver. The rest were lawyers, clerks, or students.

### *Dr. N's Group I*

The roster was 13. The maximal attendance was 7, reached in Meeting 4. The group was closed; it met twice a week for the first 56 meetings and once a week thereafter. By Meeting 57 there were 5 patients left; these remained until Meeting 101, when the group was disbanded.

*Race and religion.* All patients were white; 4 Jews, 3 Catholics, and 6 Protestants were included.

*Military service.* All patients had been in military service for 2½ years or more. Nine had been overseas; 6 had been in combat.

*Diagnosis and minimal duration of illness.* All patients were diagnosed as having neuroses, including somatization reactions, conversion

reactions, and anxiety reactions. Minimal duration of illness ranged from 1 to 26 months. (The patient who sought treatment a month after being discharged had been hospitalized in the Army for 18 months.)

*Age and marital status.* Ages ranged from 22 to 36 years, with 4 patients over 29. Five were married, 7 were single, and 1 was divorced.

*Education and occupation.* All but 1 patient had finished high school or gone beyond. The group included a laborer, a bartender, students, and white collar workers.

### ***Dr. N's Group II***

The roster was 15 patients, each of whom attended at least 1 meeting. Nine patients were present at the first meeting, and this was the maximum attendance. It met twice a week for the first 72 meetings and once a week thereafter. At Meeting 60, there were 4 patients left. One patient was added in Meeting 62 from Dr. N's Group I, which had disbanded. These 5 patients were still in treatment at Meeting 98, when the study was concluded.

*Race and religion.* All patients were white. The group included 2 Jews, 7 Catholics, and 6 Protestants.

*Military service.* All patients had been in military service for a year or more. Ten had been overseas and 6 had been in combat.

*Diagnosis and minimal duration of illness.* The group included 1 epileptic, 1 schizoid personality, and 1 patient with paranoid trends. The remainder had diagnoses of conversion reactions, obsessive reactions, anxiety reactions, or somatization reactions. Minimal duration of illness ranged from 2 months to 4 years, although all the patients had actually been sick at least a year.

*Age and marital status.* Ages ranged from 21 to 39 years, with 6 patients in their 20's and 9 in their 30's. Two were divorced, 5 were single, and 8 married.

*Education and occupation.* Education ranged from tenth grade to an M.A. degree. Three had not completed high school; 7 had completed or were in college. One was a skilled laborer; the others were students, professional men, or white collar workers.



### *Dr. N's Group III\**

This group began with 6 patients, 1 of whom dropped out after 2 sessions. Two patients from Dr. N's Group iv were added at Meeting 13. No other new members were introduced. Seven remained until observations were discontinued at Meeting 29.

*Race and religion.* All patients were white. The combined groups included 1 Jew, 3 Protestants, and 4 Catholics.

*Military service.* All patients had been in combat.

*Diagnosis and minimal duration of illness.* The patients in this group were diagnosed as having somatization reactions, phobic reactions, or anxiety reactions. Minimal duration of illness ranged from 27 to 43 months.

*Age and marital status.* All patients except 1 were in their 20's. Six were married.

*Education and occupation.* All but 2 patients had finished high school or gone beyond. Four of the patients were white collar workers, 2 were mechanics, and 2 were students.

### *Dr. N's Group IV*

The roster was 3 patients, all of whom were white. One left after his first session. After Meeting 8 the others were transferred to Dr. N's Group III; they are included in the above tabulation of Dr. N's Group III.

### *Dr. P's Group I*

The roster was 14 patients. A maximal attendance of 7 was reached at Meetings 18 and 20. The group was a closed one. By Meeting 25, there were 6 patients left. These were in treatment when the observation period ended at Meeting 34.

*Race and religion.* This group included 2 Negroes. One patient was a Seventh Day Adventist, and 4 were Catholics; the rest were Protestants.

*Military service.* All patients had been in military service for 1½

\*The composition of this group is considered in detail in Chapter iv.

years or more. All except 2 had been overseas, and all except 4 had seen combat.

*Diagnosis and minimal duration of illness.* The group included 1 schizophrenic and 4 schizoid personalities. The rest were diagnosed as having neuroses, including somatization reactions, obsessive reactions, phobic reactions, and anxiety reactions. Minimal duration of illness ranged from 17 to 34 months.

*Age and marital status.* Ages ranged from 22 to 38 years, with 2 patients older than 29. One patient was divorced; 5 were married.

*Education and occupation.* All but 2 patients had finished high school. Seven were students, 2 skilled laborers, and the rest white collar workers.

### ***Dr. P's Group II***

The roster of this group was 7, all of them extremely sick patients who had been treated individually for over a year without success and were placed in a group to see what would happen. A maximal attendance of 6 was reached at Meeting 2, and there was an average attendance of 4. The group was closed. By Meeting 8, there were 2 patients left. These were still in treatment when observation ended at Meeting 10.

*Race and religion.* Three patients were Negroes and 4 were white. All patients were Protestant.

*Military service.* One patient had been in military service for 3 months; others had been in for a year or more. Two patients had been overseas, and 1 had seen combat.

*Diagnosis and minimal duration of illness.* The group included two schizophrenics in partial remission; the rest were neurotics having conversion reactions, depressive reactions, neurasthenic reactions, or anxiety reactions. Minimal duration of illness ranged from 1½ to 3½ years.

*Age and marital status.* Ages ranged from 24 to 40 years, with all except 2 patients in their 30's. Four were married, the rest single.

*Education and occupation.* The educational level ranged from 2 years of high school to 1 year of college. One patient was a shoe re-

pairman. The rest were non-professional white collar workers; post office employees, students, clerks, and the like.

### *Dr. R's Group I*

The roster of this group was 14, some of whom attended only 1 meeting. A maximal attendance of 10 was reached at Meeting 6. There were 7 patients left when observation ended at Meeting 37.

*Race and religion.* All patients were white. One was Jewish, 2 were Catholic, and the rest were Protestant.

*Military service.* All patients had been in service for a year or more. Three had been overseas, and 1 had seen combat.

*Diagnosis and minimal duration of illness.* This group included 1 anti-social personality, 2 schizoid personalities, 1 immaturity reaction, 1 conversion reaction, 3 obsessive-compulsive reactions, 2 anxiety reactions. Minimal duration of illness ranged from 2 to 16 months.

*Age and marital status.* Ages ranged from 21 to 36 years. Seven patients were married, and 7 single.

*Education and occupation.* The least-educated patient was a junior high school graduate; the most-educated had a master's degree in law. The group included a lawyer, a mechanic, a machine operator, an insurance salesman, and clerks.

### *Dr. R's Group II*

Seven were on the roster, which remained open. A new member was introduced as late as 5 months after the group started. It was one of the first to be observed, and we used it to test observational methods. Three patients formed the core; the others attended irregularly.

*Race and religion.* All patients were white. Three were Catholic, the rest were Protestant.

*Military service.* All had had over 2½ years of military service, and 2 had seen overseas duty.

*Diagnosis.* Of the 3 regular patients, 1 was diagnosed as having an anxiety reaction, 1 as having anxiety with depressive features, and 1 as having a dissociative reaction. The 4 other patients had diagnoses of anxiety with conversion features and depressive reactions.

*Age and marital status.* Ages ranged from 25 to 32 years. Three patients were single, 3 married, and 1 divorced.

*Education and occupation.* One patient was a bellhop and waiter, 3 were government clerks, 1 an apprentice mechanic, 1 a student, and 1 a maintenance man in the fire department.

### ***Dr. X's Group***

The roster was 14. The maximal attendance of 8 was reached in Meeting 9. There was an average attendance of 5 for the 26 meetings observed.

*Race and religion.* All patients were white. Except for 3 Catholics, all were Protestant.

*Military service.* Length of military service ranged from 2½ to 5½ years. Twelve patients had been overseas, and 9 had seen combat. Ten had been officers.

*Diagnosis and minimal duration of illness.* All patients were diagnosed as neurotics; 5 were alcoholics. Minimal duration of illness ranged from 11 to 32 months.

*Age and marital status.* Ages ranged from 24 to 49 years, with only 3 patients in their 20's. Eight were married, 3 were single, 1 was separated, and 2 were divorced.

*Education and occupation.* All patients had had some college work or professional training. The group included students, writers, research workers, and clerks.

### ***Dr. Z's Group***

The roster was 7. A maximal attendance of 5 was reached at Meeting 3, and these patients remained until Meeting 23, when observation ended.

*Race and religion.* All patients were white; 1 Protestant, 2 Catholics, and 4 Jews were included.

*Military service.* All patients had been in military service for 1½ years or more; 6 had been overseas, and 1 had been in combat.

*Diagnosis and minimal duration of illness.* The group included 1 psychotic in remission, 1 schizoid personality, 1 alcoholic with paranoid



trends, 1 inadequate personality, and 3 patients with obsessive reactions. Minimal duration of illness ranged from 2 to 4 years.

*Age and marital status.* Ages ranged from 22 to 34 years, with all except 1 patient under 29. Three were married; 4 were single.

*Education and occupation.* Two patients had completed tenth grade, 2 had completed high school, the other 3 had finished college or at least done some college work. One was a service station attendant, the others students or white collar workers.

### PREPARATION OF PATIENTS FOR GROUP THERAPY

Preparing the patient for entrance to the group was primarily the responsibility of the psychiatrist conducting the group (if the patient was assigned to him) in one or more preliminary interviews. As there was little in the literature to serve as a guide, the doctor followed the practice in general use for introducing patients to psychotherapy. He helped the patient to define his presenting problem and to see some of the possibilities for amelioration through therapy. Instead of taking a systematic history of the patient's life (which would have been likely to hamper the therapeutic relationship) he allowed the patient to tell his story in his own way but meanwhile tried to keep the discussion focused on significant problems and their relation to each other, the patient's feelings, and possibly his past.

In addition, the psychiatrist tried to bring out any misconceptions, questions, and doubts the patient might have about group therapy. He discussed these in developing the therapeutic relationship as any doctor would talk over a form of treatment he was prescribing. His statements about the group and its conduct were not didactic, nor did he give set descriptions or attempt intellectual presentations. It was the consensus of our staff that statements to the effect that the patient would be able to help others and they him, were of dubious value. In answer to direct questions, our doctors were apt to say that the group is a place for patients to study their feelings toward others and toward themselves and the influence of those feelings in their daily life.

The way in which the idea of the group was presented seemed to

determine to some extent the way in which the patient perceived it, at least at the start, and the way he behaved in it. In Dr. N's Group II, for example, the patients were told that the group was a place in which they could discuss their problems, and here they tended to be self-revealing. In his Groups III and IV, where the opportunity to examine their relations to one another was stressed, they tended to examine group processes—although, of course, in terms of their problems.

We do not have enough data to indicate which of three methods is most effective in securing attendance. The first, which we have not tested, is to prescribe group therapy without a preliminary interview. The second is to see the patients often enough to get some ideas of their problems, particularly in relation to other people, and then offer group therapy as a way of studying these directly. The third is to give patients a good start through individual therapy before placing them in a group. The last two alternatives, both of which were used at the clinic, seemed to make the inexperienced doctor more secure in that they enabled him to think about and make tentative plans for dealing with problems likely to come up in the first meetings.

In addition to their general therapeutic value, a few individual sessions with a patient before he was placed in a group undoubtedly had some advantages with reference to group therapy. They enabled the doctor to get acquainted with the patient, his problems and sensitivities, and to use this information in composing groups and in thinking about how to deal with the problems of early meetings. They afforded a chance to elicit and explore the patient's reactions to being told he was to be placed in a group, which were often of great relevance to therapy. Preliminary individual sessions also gave the patient an opportunity to get acquainted with the doctor. On arrival at the first group meeting he found a person who was familiar and who had already shown himself acceptant and understanding. Individual sessions also enabled the patient to obtain some idea as to how therapy would proceed and what to expect in the group. Thus preliminary interviews tended to diminish the anxiety and confusion which are inevitably present at the first meeting of a group.

Almost half the clinic patients who were enrolled in groups re-

mained in therapy, regardless of the relative experience of the doctor or of his method of preparing patients for the group. The patients' attendance bore no relation to their initial reaction to the idea of group therapy. The data on this point show that of 14 patients who showed favorable responses, ranging from passive consent to eager acquiescence, 7 remained in therapy for more than 5 sessions, 4 attended less than 5 sessions, and 3 failed to appear at all. Of 13 who showed responses ranging from open rejection to evasiveness, 8 attended more than 5 sessions, 1 less than 5, and 4 did not come to any group meeting. As in all psychotherapy, the patients' expressed reactions often bore little relation to their real feelings or intentions. Our general impression is that whether patients remain in group therapy depends primarily on the relationship established with the doctor beforehand and on the events of the first few meetings.

Frequently, the reactions shown by patients on being told about the group afforded material for therapy. Some patients felt that they had nothing in common with others or had a fear or dislike of groups *per se*, as is illustrated by the case of one patient who had a vivid fantasy life and had largely withdrawn from people. After six months of individual treatment he was offered group therapy as a means of helping him establish a closer touch with reality. The doctor stressed that the patient might participate as little or as much as he wanted to. When he agreed to come on this condition, he immediately recognized his old tendency to hang back from any group activity. He attended group meetings with marked therapeutic progress until the project was terminated two years later. Another patient refused to enter a group, but for a month after the subject was mentioned he discussed his problems in groups of his friends. He then spontaneously asked to join a group and worked very well in it. Another patient refused to join a group, having left medical school because of an overwhelming feeling of failure when called on to speak in class. In this patient's third individual session the doctor persuaded him to join a group so that he could see for himself how his shyness operated, and at the first meeting he attended the doctor invited him to participate. When he replied that he would rather listen, his wish was respected. Later on, he made a few spontaneous remarks. Before the end of the first

meeting he spoke at length of his history of failure in groups, and thereafter he participated freely.

Other patients said that they were afraid of exposing themselves before others, as for example, the patient who insisted that he could not possibly reveal his illegitimacy to a group. He remained during the first and second meetings but showed by his reactions that he was participating emotionally. After the second meeting, when members of the group were standing informally on the steps, another patient remarked that the first patient must be in A-1 shape because he had not mentioned any problems. He suddenly blurted out that he was illegitimate, and the group discussed his problem at length; at subsequent meetings he talked freely. Another patient said that he could not possibly talk about personal matters. The doctor stressed that he did not have to talk about anything but that the group might help him to see how he reacted toward others and to realize that the thoughts and feelings he was so ashamed of were shared by others. This patient also attended regularly and became an active member.

The fear of expressing or encountering hostility makes some people hesitate to join a group. One of our patients was afraid of being upset by anti-Semitic remarks. His anxiety about being Jewish was sufficiently relieved in individual sessions to enable him to join a group. At the second meeting, when he was accused of always having a chip on his shoulder, he explained his fear of being rejected because he was Jewish. After anti-Semitism had been discussed in the group, he experienced a considerable decrease in his anxiety and continued to attend meetings.

Other important ideas and attitudes may arise when group therapy is mentioned. A certain patient thought that the doctor was trying to get rid of him by asking him to join a group. Later he said that he had caught himself thinking how he would behave at the first meeting so as to make a good impression and had realized how this contributed to his tension and constituted a characteristic pattern. Another patient, who had very little social life outside the classroom, responded enthusiastically to the invitation to join a group, saying that it would give him a chance to discuss the Negro problem. This led him to analyze his tendency to go out of his way to champion Negroes



and to relate this to his feeling of rejection because he had a Jewish name and one Jewish grandparent, although he had been reared as a Catholic. The doctor did not enroll this patient in a group until the latter realized that his need for association with people was more important than his need to attack them and until after some of his other social concepts had become less distorted.

## EVALUATION OF THE RESULTS

In evaluating each patient we compared a consensual appraisal made at the beginning of treatment with another made when he left therapy or at the end of the experiment. We relied primarily on the joint study of data supplied by the patient's doctor, psychologist, social worker, and group observer. The doctor made the initial contact with the patient, as described above, and in addition he obtained as much information as possible on the connection between the patient's complaints and emotional conflicts or difficulties in interpersonal relationships. From these he obtained clues on which he based his judgment of therapeutic possibilities (see Appendix c).

The social worker's interview was designed to supply a systematic account of the patient's statements about his relations with other persons and it included, when relevant, information about his parents, wife, children, workmates, schoolmates, and friends of both sexes. The interview was conducted so as to bring out his perceptions of these persons, how he felt about them, what feelings he could or could not express in their presence and the purpose of his behavior toward them. At the end of treatment and in some cases also during it, the social worker obtained the patient's impressions of what he thought had happened as a result of the group therapy. It was thought that the patient might not consider the social worker as personally involved in the success of the group and that he therefore might give a more objective report to the social worker than to the doctor (see Appendix d).

The psychological tests supplied a relatively standard situation and a constant frame of reference for comparing patients with one another and with themselves before and after treatment in terms of



their habitual or changed ways of dealing with stimuli. The main weight was placed on the Rorschach test, which was used in such a way as to focus particularly on the patient's accessibility to emotional stimulation—whether he responded directly to it or defended himself against it by repression, avoidance, or other mechanisms, how successful his defenses were, and to what extent they were flexible. The psychological tests also described the patient's contact with reality and the accuracy and extent of his picture of himself, including his insight into the relation of his symptoms to his emotions and problems, the relation of his goals to his abilities, the freedom with which he expressed his feelings, his intelligence and drive and the extent to which they were used constructively or dissipated in ineffectual fantasy or unproductivity, and the strength of his self-esteem (see Appendix E).

The data obtained by the doctor, psychologist, and social worker supplemented one another. The doctor's data on the patient's symptoms might be expanded by more detailed information from the interpersonal-relations interview on the particular social situations which aggravated or alleviated them, while the psychological tests might reveal underlying disturbances in mood and thinking that were different from those openly displayed. The doctor's data on the patient's conflicts might also be corroborated and supplemented by specific examples of his social adjustment taken from the social worker's report and by information about the underlying dynamics of his personality taken from the tests. Furthermore the patient might show different aspects of himself to different interviewers in accordance with his perception of their relation to him. His responses to the psychologist and social worker, for example, might be influenced by whether he saw them as independent investigators or as persons serving as deputies for the doctor but lacking his healing function. The patient might exaggerate his distress to get further treatment or minimize it to impress the doctor with his progress. The transference and counter-transference might cause distortions in what the patient presented or in what the interviewer perceived and how he interpreted it.

At the close of the observed period of treatment the information on each patient obtained from these sources was considered in a staff

conference and changes were evaluated and summarized\* in terms of:

1. Symptoms: physical, mental, and emotional
2. Social relations: how the patient got along with others at home, at work, and elsewhere
3. The patient's characteristic responses to stimuli, which might be neurotic or useful and satisfying. The neurotic responses might be partly expressed in the symptoms. Healthy as well as neurotic responses might be reflected in the social relations.

Although these three areas of possible change were obviously inter-related, they were independent to some extent. It therefore seemed necessary to consider them separately for clarity in making comparisons. In each of these areas we tried to distinguish two degrees of change, (1) slight and (2) marked, based not on formal criteria, but on the consensus of those who evaluated the patient, with the chief weight being given to the doctor's judgment. This permitted a breakdown into area of improvement on the one hand, and degree of improvement on the other. The latter measure was obtained by totaling the numbers, regardless of the category in which they occur. This yielded a range of improvement of 1 to 6. The relation between degree of change and areas of change can be summed up as follows:

Range of improvement	Degree
Slight improvement in one area only.	1
Cannot involve more than two areas—slightly improved in each or markedly improved in one.	2
Cannot involve less than two areas—marked improvement in one and slight in the other; or slight improvement in all three.	3
May indicate marked improvement in two areas or marked in one and slight in the other two.	4
Cannot involve less than three areas, with marked improvement in two, slight in the third.	5
Marked improvement in all three areas.	6

It was relatively easy to determine whether changes in symptoms or social relations represented clinical improvement. In respect to characteristic responses to stimuli, it was necessary to consider not only the nature and extent of the changes, but whether they represented a move toward or away from the optimum for that particular

\*An example of such a summary is given at the end of Appendix F.

patient. Changes in these responses were regarded as improvement if they were concomitant with improvement in symptoms or social relations, or as the reverse in the few cases in which the latter two categories showed a change for the worse.

We used our knowledge of the patient's past history in arriving at our appraisal of the patient at the beginning and the end of the period of observation. The history was necessary for the understanding of the present psychopathological status and its amelioration, but we did not include the historical material in the actual evaluation summaries. In these we were concerned only with the changes in the patient's attitudes and behavior in the three areas indicated. That is, we adhered to the field-theoretical rather than the historical approach,<sup>2</sup> in the conviction that a person's actions are best understood in terms of what they mean here and now, with reference to the total situation, and that only attitudes which are operative at the time can directly influence his behavior.

A cross-sectional evaluation of the patient's condition while undergoing therapy may give a misleading picture. Although he may appear clinically worse at the time of examination, this may represent a necessary step toward improvement. At some point in a successful course of psychotherapy almost every patient feels worse, or is getting into more open difficulties with others, than before treatment started. Although treatment was continued when indicated after observation stopped, subsequent improvement was not included in the study.

An attempt was made to evaluate the effect of group therapy on the patient through consideration of his changing behavior in the group and his statements about reactions to the group. For those patients who received group and individual treatment an attempt was made to estimate the relative importance of each in the improvement of the patient without trying to describe precisely the part played by each. As a matter of fact, the two might be so intermingled and mutually helpful that a precise evaluation would be impossible in some cases.

Our data do not permit comparison of the results of group treatment with those of individual treatment, or of group therapy with combined group and individual therapy. In our experiment there were too few

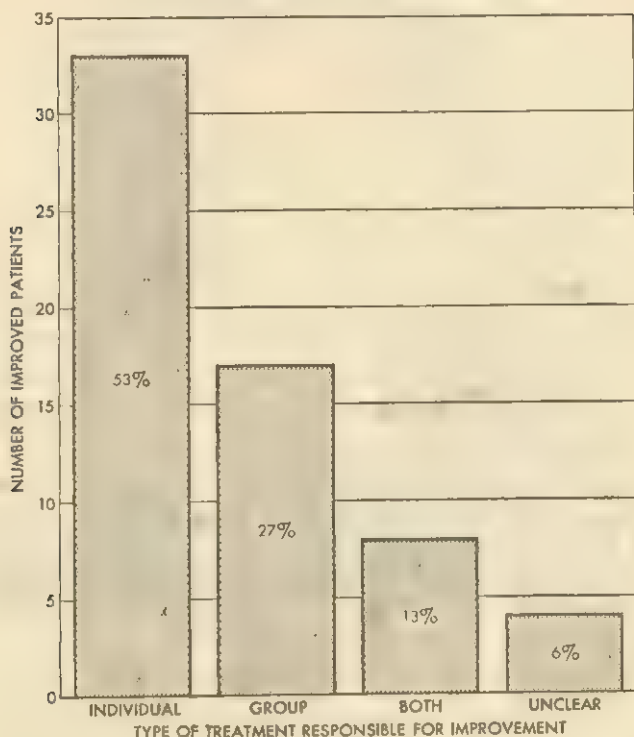
DOCTORS' EVALUATION OF TYPE OF TREATMENT  
FOR 62 PATIENTS WHO IMPROVED

CHART 2

subjects and too many uncontrolled variables, such as differences in patients, in doctors, and in periods of observation. Furthermore, our evaluations of the patients' improvement (see Table 3) were probably adversely affected by the shortness of our period of observation and by the inexperience of our doctors with group therapy. In the early groups, at least, therapy probably fell far short of its maximal effectiveness. The figures are probably more indicative of the kind of results that might be expected upon introduction of group therapy into a clinic than of its ultimate potentiality.

The following statistics, then, are presented solely to illustrate a way of analyzing improvement which we believe to be possible.

In 17 cases, or 27 per cent of the 62 patients who improved under both individual and group therapy (see Chart 2 and Table 3),

### DEGREE OF IMPROVEMENT AS RELATED TO DURATION OF OBSERVED TREATMENT

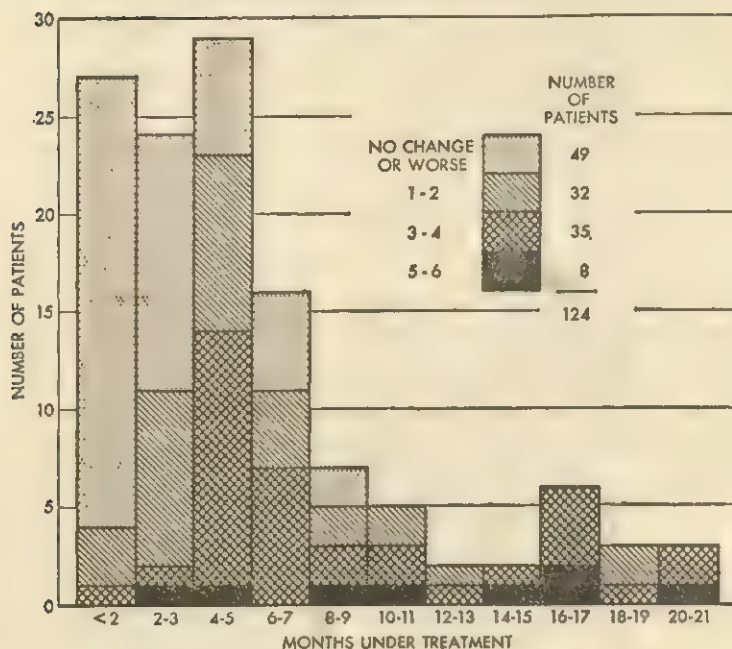


CHART 3

the doctors considered the main weight of therapy to have been carried by the group, despite the more intensive personal contact provided by individual sessions. For 8 additional patients, or 13 per cent, they considered the group to have been at least as important as the individual sessions. Thus the group was counted an important factor in the improvement of about 40 per cent of the patients who responded to combined treatment. This finding gains in significance when it is remembered that the doctors' only previous experience had been with individual therapy, so that they would have tended to be biased in its favor.

Sixteen patients (13 per cent) were observed for a year or more, and 83 (67 per cent) were observed for less than 6 months. Since many patients dropped out within the first 4 months of therapy, it is not surprising that the average period of observation for individual patients was briefer than that for groups. As might be expected, there is a positive relation between duration of treatment and both the



number of patients improved and the degree of improvement achieved (Chart 3). Of the 8 patients showing marked improvement, 6 had over 7 months of treatment, and all having over 9 months of treatment showed improvement. It is of interest that 2 patients were scored as markedly improved after less than 6 months of treatment. One had group treatment only and obtained striking benefit from a few sessions (see Appendix F).

Table 3 summarizes the over-all improvement of our patients. Patients who achieved a rating of at least "slightly improved" in either symptoms or relationships, or a slight change in characteristic neurotic responses which was judged to indicate improvement, were scored as improved. On this basis it will be seen that, despite the brevity of the average period of observation, over 60 per cent of the patients showed some improvement. The slight difference between patients receiving group therapy only and those receiving both group and individual cannot be evaluated because too many variables were uncontrolled and the number involved was too small.

Of the 5 patients who were scored as "worse," 4 were only slightly so. The change was in each case due to a weakening of defenses, with a welling up of more manifestations of illness, which is often observed in the course of therapy. Moreover, as none of these patients were observed for more than 7 months (4 were observed for less than 4 months), the increased manifestations of illness might well have subsided as therapy continued.

In Table 4 the results are analyzed in terms of degree of improvement. It appears that about half the patients who improved showed moderate improvement (3-4 degrees), regardless of whether they received group therapy alone or a combination of group and individual treatment.

In Table 5 improvement is broken down by areas regardless of degree. It may be significant, particularly in view of the shortness of the period of observation, that about a third of the patients who benefited showed improvement in all three areas, whether they received group therapy alone or individual treatment as well.

Improvement with reference to clinical diagnosis revealed nothing unexpected. Review of the literature shows that most of the patients

whom psychiatrists found unsuitable for groups would have been difficult to treat with any type of psychotherapy. Such patients include psychopaths, severe obsessional neurotics, and paranoid and schizoid personalities. There is nothing in our data to indicate that these patients were basically any more unsuitable for our type of group therapy than for any other type of psychotherapy. Some patients with these diagnoses failed to improve in certain of our groups, but similar patients remained in other groups and derived some benefit. The patients who would have been least expected to improve under brief psychotherapy were the alcoholics and the psychotics. (It will be recalled that there were no psychopaths.) Of the 6 patients for whom drinking was a major problem, 4 showed no improvement, 1 achieved a 2-rating, and 1 a 3-rating, and all left group therapy while still under observation. They received both group and individual treatment.

Of the 9 patients classed as psychotic, all of whom received both group and individual treatment, 2 showed marked improvement; these were observed under treatment for 11 and 21 months, respectively. Three showed minimal improvement. The remaining 4 showed no improvement, but 3 of these left treatment within 3 months.

A promising approach seemed to lie in searching the data to see if there were any recurring patterns involving symptoms, social relations, personality trends, and reactions to the group. To do this, we had to see first if the data yielded any categories into which symptoms, social relations, and personality trends fitted. The following percentages represent those patients who showed improvement in certain categories, selected because they were most frequently represented or seemed most significant in relation to therapy. Either the other patients failed to show improvement in this category or the data failed to mention it. Since the categories were only roughly delineated at this stage, they probably have considerable overlap.

In the 43 patients showing moderate or greater improvement (3-6 degrees), the symptoms most frequently ameliorated under treatment were subjective anxiety, including panic states and phobias: 53 per cent; somatic complaints: 47 per cent; rumination, including mulling over the past, worry about the future, and daydreaming: 26 per cent;

TABLE 3. Evaluation of Patients' Improvement

	ALL PATIENTS	WORSE		NO CHANGE		IMPROVED	
		Per		Per		Per	
		No.	cent	No.	cent	No.	cent
Only group therapy	24	1	4	10	42	13	54
Individual and group therapy	100	4	4	34	34	62	62
TOTAL	124	5	4	44	35	75	61

TABLE 4. Frequency of Different Degrees of Improvement\*

	PATIENTS IMPROVED (TABLE 3)	DEGREES OF IMPROVEMENT					
		1-2		3-4		5-6	
		No.	Per cent	No.	Per cent	No.	Per cent
Only group therapy	18	5	38	7	54	1	8
Individual and group therapy	62	27	44	28	45	7	11
TOTAL	75	32	43	35	47	8	10

TABLE 5. Areas of Improvement\*

	PATIENTS IMPROVED (TABLE 3)	IMPROVED IN ONE AREA ONLY		IMPROVED IN TWO AREAS		IMPROVED IN THREE AREAS	
		Per		Per		Per	
		No.	cent	No.	cent	No.	cent
Only group therapy	18	3	23	6	46	4	31
Individual and group therapy	62	17	27	17	27	28	46
TOTAL	75	20	27	23	31	32	42

\*See explanation, p. 57.

and depression, including concentration and memory difficulties and guilt and self-depreciatory feelings: 24 per cent.

The patterns of social relations most frequently showing improvement were expressiveness, including greater ability in self-expression and self-assertion: 45 per cent; isolation, including seclusiveness and feelings of uniqueness: 37 per cent; and uneasiness with people, including ambivalence, resentful dependence, and competitiveness: 31 per cent.

The personality trends most frequently showing improvement were general effectiveness, including more constructive use of fantasy, better mobilization of assets, increased self-confidence, greater ability to take the initiative, greater ability to handle stimuli: 45 per cent (some patients achieved greater effectiveness by limiting their goals or setting themselves easier tasks, which they could then handle in a more organized way); self-awareness, including more insight into the nature of one's own feelings and how they develop in response to earlier life experiences: 42 per cent; and objectivity, including less perceptual distortion, less fantasy, and more accurate appraisal of oneself in relation to others: 37 per cent.

We tried to relate these categories to one another and to the type of therapy; we were able to do so only for patients whose major symptoms included rumination. Ten of the patients who showed improvement of + 3 or more became less ruminative (with or without improvement in other symptoms), and all but 1 showed tendencies toward greater ease with others and/or less isolation. Four of the 10 improved in both these categories, 3 only in feeling easier with people, and 2 only in feeling closer to them. The tenth became superficially more sociable, but his feelings of loneliness had increased as his techniques of relating superficially improved. Seven, following treatment, showed greater objectivity.

Three of these 10 patients had improved with group therapy alone, and 7 with group and individual therapy. Doctors and patients alike believed the group to have played little part in the improvement of 4 of the patients in the latter category, to have been as important as individual sessions for 2, and to have been more important for 1. The remaining 3 patients improved with group therapy alone. At

first all 10 patients had shown uneasiness in the group by tense silence or compulsive monopolizing; none were able to participate in a spontaneous way. Those who were helped by group therapy seemed to have derived benefit from the incentive of fellow patients and from the opportunity they found in the group to practice relating to others on a give-and-take basis. This included learning to associate profitably to the material and feelings of others, discovering that attitudes which they had regarded as unacceptable did not shock the group as they had feared, and correcting in various ways the distortions in their relations with others.

These findings suggest that, although isolated, ruminative patients find the group situation difficult, it may be of considerable benefit to them if they can tolerate it long enough to get beyond their initial uneasiness. The fact that all 6 patients who found the group an important help were treated by the same psychiatrist (one of the more experienced on our staff) suggests that it is often possible for the doctor to smooth the path for patients of the isolated, ruminative type. It should be stressed that the 6 described above had a variety of clinical diagnoses, including ambulatory schizophrenia, depression with hysterical features, psychogenic neuro-muscular reactions, and epilepsy.



## CHAPTER IV

### *Group Composition*

---

THE effective composition of therapeutic groups is a problem which is generally recognized as one of the most difficult in group therapy. It cannot be solved without much more research, since composition is inseparable from all other aspects of group therapy. Whether or not a given individual will do well in a group depends not only on his personal attributes, but on how they will interact with those of other members in a group organized for a particular purpose and conducted in a particular way. Consideration of composition will probably prove to be quite different for analytically oriented as opposed to repressive-inspirational groups, for "open" and "closed" groups, for groups in different settings—mental hygiene clinics, hospitals, reformatories, counseling centers, and so on. Furthermore, any two group leaders using the same type of therapy in the same setting will differ in personal attributes, in training and experience, in style of therapy, in the way they encourage or discourage patients, and all these factors will have a relation to different types of patients and therefore to the composition of groups. Our understanding of ways of composing groups can progress only as fast as our knowledge of other aspects of group therapy.

On the basis of our experience we concluded that, except for alcoholism, none of the attributes usually considered in grouping—age, intelligence, education, marital status, clinical diagnosis—are significant in themselves, either in determining which patients are suitable for group therapy or in selecting those to be treated in the same group. Similarities or differences in any one of these factors may be important in a particular group under special circumstances, but their effect can be understood only in terms of their importance to the issues with

which the patients were concerned at the time. In short, we share the opinion of most workers in the field of group dynamics that the most promising approach to the problem of composition is the situational one.

When differences are not too radical, they often tend to assist therapy by exposing patients to a wide range of attitudes and by increasing intra-group tensions. In groups in which free expression is acceptable it is particularly helpful to include members who have closely related problems that they meet in opposite ways (see Chapter x).

It is inadvisable, of course, that members of a given group be so different that communication is virtually impossible. For example: at one time or another Dr. X's group contained five alcoholics; none did well in the group, and all tended to disrupt it. This was in keeping with the usual finding that an alcoholic does not fit into a group of non-alcoholics because of his excessive talkativeness, his need to dramatize himself and to emphasize his uniqueness, and the fact that the problems of the alcoholic "make no sense" (as one patient put it) to the neurotic. The alcoholic may, of course, do well in a group of his fellows. In groups led by two other doctors it also became clear that, for reasons unrelated to alcoholism, the attributes of certain patients were too different to permit successful communication.

Although patients in a group may be too different to work together, it does not follow that the more similar they are the more successful the group is. This frequently expressed view seems to us an oversimplification.<sup>1,2</sup> The combination of patients who have a lot in common facilitates mutual identification and the finding of topics for discussion but in itself need not be therapeutic. Under certain conditions similarities may even help patients to strengthen each other's neurotic behavior by building up mutual support, as in the following example.

Two patients in Dr. X's Group, Hastings and Grey, were professionally associated in radio work and both came to the clinic after their wives had made the initial contact. The wives were concerned with the anxiety symptoms appearing during intervals when the men abstained from alcohol. Both men were egocentric, contemptuous of associates, and unable to express their rebellious attitudes to superiors.

Both left jobs when they felt that their work was not appreciated. Both had paranoid tendencies and had been admired as bright and precocious children. Both seemed to feel that they got the group's attention only when they were dramatic and entertaining. Both sought a dependent relation with Dr. X by humiliating themselves. Hastings dramatized his troubles but at the same time refused help. A strong rivalry with a brother may have intensified his relationship with Grey.

At meetings which both attended Hastings was ingratiating—subordinating his problems to Grey's and supporting him. Grey used Hastings as a foil to aid him in resisting treatment. Hastings was acquiescent: for example, when Dr. X asked the group to evaluate an incident Hastings suggested that Grey had benefited from "the unburdening." When Dr. X suggested to Grey that the latter had felt better after telling off the doctor, Grey defensively misquoted Hastings. "Like Joe says, it was the distraction, not my telling you off, that made me feel better." Hastings later made an effort to show Dr. X that, contrary to his usual overly controlled attitude, he sometimes really showed annoyance with others. He gave an example of irritation with a colleague, and Grey, claiming to know the man in question, said that Hastings' feeling was justified and told further anecdotes to prove the point. Shortly afterwards, when the doctor recommended that the patients examine their feelings and remarked that Hastings looked bored, Grey interrupted protectively to caricature a dying man checking his feelings. At another meeting, noting that Grey looked bored, Dr. X suggested that he resented the time given to other patients; when he asked Hastings to confirm his impression that Grey was hiding behind boredom, Hastings replied, "If he is, I'm hiding back there with him." Here Dr. X, by calling on Hastings, gave him an opportunity to continue his pattern of supporting Grey's resistance.

When Grey was absent, Hastings at first adopted an arrogant attitude and monopolized the meeting. Later, in Grey's absence, Hastings relaxed, sought the group's advice, and admitted that his politeness was only a front.

#### INDIVIDUAL DIFFERENCES AND THE GROUP SITUATION

The following examples show how the effects of differences in diagnosis, education, race, religion and cultural background, age and life experience depend on their relation to the particular group situation, including the issues with which the patients are concerned at the time and the attitudes of the therapist.

*Clinical Diagnosis (Schizophrenia)*

Even a patient with gross schizophrenic manifestations might participate helpfully at times in a group of neurotics, as in the following example:

Dr. P's Group I contained a patient named Thaddeus, a very sick schizophrenic, on a trial visit from a hospital, who could participate lucidly at times, but whose symbolic speech usually led others to ignore him. He seemed to benefit, nevertheless, from his brief experience in the group.

When another patient interrupted Thaddeus at his first group meeting, he remarked to Dr. P that he was not bothered by what the others had to say. Later, in symbolic terms, he reiterated his ability to exclude certain information categorically: "A man who eats a turkey dinner between 11 and 12 o'clock may say he has not had dinner because dinnertime is noon."

Later in the meeting, when a patient expressed concern about masturbation, Thaddeus participated appropriately. He asked whether masturbation has any effect on the mind. When the group suggested that the resulting fatigue makes one nervous, Thaddeus interpolated, "It lessens your self-confidence," and then advised against feeling guilty about it on the ground that "all men are created equal." Thaddeus was ingratiating through most of the meeting and concluded with the remark, "Making friends for some people takes great patience."

At the next meeting, after Thaddeus had been cut out several times by other patients, he spoke obscurely about saving money to buy a four-engined Liberator and going fishing in Bermuda. He mentioned that he had been making money at a clerical job in addition to going to school. When Dr. N, who was substituting for Dr. P at this meeting, tried to orient Thaddeus with a question about financial arrangements, Thaddeus said that he figured he needed \$25,000. If his jewelry wasn't enough, he said, he had "an old rifle."

*Clinical Diagnosis (Paranoid State)*

Dr. N's Group II contained a paranoid patient whose condition bordered on the psychotic—a type of patient usually considered unsuitable for group therapy. The situation analysis given below illustrates how the group finally learned not to be upset by his explosive outbursts. This adjustment resulted in some benefit to him and in a great deal to several other patients.



*Situation Analysis 1***DR. N's GROUP II, Meeting 73**

**PRESENT:** Bly, Castell, Coombs, Ingram, and Veal

**SETTING:** Castell was an extremely hostile patient who remained silent most of the time and responded to almost any expression of hostility by glowering, crying, or abruptly leaving the room. He had paranoid trends and was loath to talk in the group for fear of being called crazy. In the past, after Castell's outbursts, the group had been constrained and silent or talked of trivia. At Meeting 72 Castell had responded irrationally, accused Bly of making fun of him for being crazy, and insisted that Dr. N had put Bly up to playing this trick on him. The doctor was the only one who knew how sensitive Castell was about being called insane.

Ingram appeared bland and mild, showing his hostility indirectly. He rarely took an aggressive stand against anything. Recently there had been much analysis of his feeling that he was being "deceived" and he had finally come to see himself as being deceitful because he did not let others know his feelings. He had never been explicit about just what thoughts he did hide.

At the beginning of the present meeting the patients were tense and there were frequent silences. In an effort to get at the source of this, Dr. N reviewed the last meeting, at which intense hostility had been directed against Bly because of his monopolizing attention.

Bly finally told an anecdote about a girl, at the end of which he said, "Maybe I'm just crazy." Then he flushed and gave a sidelong look at Castell. Castell grinned, shifted in his chair, and made a rather pleasant comment to Bly. He then said excitedly that Bly seemed silly and foolish to him and made him nervous—he wondered why. Becoming more excited, Castell asked why he had to waste his time listening to "all this bunk" from Bly.

**PRECIPITATING EVENT:** Dr. N observed sympathetically that Castell looked flushed and angry and asked what the trouble was. Castell began to cry and insisted angrily that Bly was making fun of him for being crazy. When Dr. N continued to speak to him, Castell said he couldn't talk when he was so much upset and continued to sob and blow his nose. The group was tense and silent. Dr. N remained silent and relaxed, looking at Castell as though waiting for him to speak and then remarked to the group that Castell's outburst seemed to have stopped the meeting.

**EVENT:** Noting that Ingram was looking around tentatively, Dr. N said quietly, "You look as if you want to say something, Mr. Ingram."



Ingram replied that when others are upset he wants to laugh, he feels victorious. Castell glared at Ingram (who was sitting next to him)—his face a mask of fury. Ingram paid no attention to him but kept looking down at his own hands; when people are hurt, he said, he feels at ease. In response to Dr. N's questioning Ingram brought out that his mother was the first person about whom he had felt this way—he had no sympathy for her. He then calmly remarked that he had had the same feeling about prisoners of war—no pity for them, only personal gratification and a feeling of getting even. He had this feeling of triumph now—getting even for what had been done to him. When he finished there was a long, deep silence.

#### EFFECTS:

1. Dr. N broke the silence to comment quietly that it looked as if the anger had stymied everyone. Bly said that he was angry with the doctor for making this remark, because he didn't think the members of the group were stymied. Both Bly and Coombs then said that they respected Ingram for his courage in expressing his feelings in the face of Castell's rage. Bly said that he had feared a physical attack from Castell but now thought that Castell had transferred his hate to Ingram. Bly said that he had always wanted to make Castell feel good, just as he had wanted to make his father feel good; he had always wanted to get close to him, but Castell took things in the wrong way. Bly and Coombs talked about Castell as though he were not present. They gave Ingram sympathetic and admiring glances. Though both were flushed, neither Castell nor Ingram said anything during the rest of the meeting.
2. At the next meeting the members continued to discuss their feelings about each other. For example, when Dr. N suggested that the meeting begin, Bly said that he would rather wait until Castell got there. (In the past Bly had discussed Castell only if the latter were absent.) Castell was able to talk profitably about his rages and his associations to them. He said that he had wanted to beat Bly and Ingram. Ingram gained support from the members and Dr. N for having been able to talk for the first time about feelings for which he had thought everyone would hate him.
3. The group was never again silenced by Castell's outbursts, though he continued to have them. The other members simply went ahead with their discussion.

DISCUSSION: The group's ability to endure the paranoid rages of one member for so many meetings and finally to ignore them was due in large part to Dr. N's calm attitude toward the rages. Although at

times they made him tense, he did not try to protect the others from Castell but quietly encouraged them to express their reactions. His questioning of Ingram about his feelings toward his mother, a maneuver designed to relieve the tension by directing attention away from the immediate situation, was probably not necessary.

The effects of this incident were beneficial to Castell, Bly, and Ingram. Bly discovered how he was displacing attitudes toward his father to Castell. Ingram was stimulated for the first time to reveal attitudes he regarded as excessively shameful (after the meeting he seriously asked Dr. N if he would be reported to the authorities), and, finding himself encouraged instead of ostracized, he was able for the most part to express and examine his feelings more freely in later meetings. At the next meeting Castell was able to verbalize some of the feelings connected with his rages.

### *Clinical Diagnosis (Habit Disorder—Stammering)*

That the effect of stammering on the group depends to some extent on how the stammerer uses it in his relations with others, may be illustrated by the different reactions of Dr. K's Group to Steele and Malta, two stammerers who attended it at different times. Each sought to be dependent when he felt anxious and each seemed to do best when Dr. K played an active role, but their attitudes were otherwise quite different. Steele, who had the more severe stammer, seemed to get something out of treatment. Although a member of the group for a much longer period, Malta showed little improvement.

Steele monopolized attention in the group's earliest days, when the doctor was passive. While he often controlled through his stammer, he did not seek any special sympathy for it and seldom complained of it. He had the group's esteem. He had come to the group with a superficially aggressive, patronizing attitude but became less dominating after another member's discussion of his own conflict over masculinity. When Dr. K took a more active part, Steele was able to discuss the passive role which he fantasied for himself. After Steele departed from the group for overseas duty Malta came in.

Malta seemed to get along fairly well at first. He talked about himself and answered the questions of others. Several months later, when Dr. K again became less active and the group assumed more responsibility, Malta's dependency became more evident. Several members tried to help him find the reason why he felt as though he did not

belong in any group. He and they blamed his lower education and occupational level and his speech difficulty. But this explanation did not prove helpful, and Malta continued his complaints about his dependency and his stammer, apparently relying on the latter to elicit help from the group. In individual sessions the other patients complained of his stammer but not of Steele's. They were annoyed at Malta because he impeded the progress of the group, and they apparently used his stammer as an excuse for rejecting him.

### *Education*

The following examples illustrate how the significance of differences in education varied from group to group—depending on other personality problems of the members and other issues at stake.

Weber, a patient in Dr. N's Group I, related his excessive desire for advancement on the job to his insufficient education. He later brought out that he felt out of place at work because the other men were more creative. On the one hand he said that he knew that he could have a profession, and on the other that his abilities "wouldn't warrant it." His mother had wanted him to have a profession, but she had had a prolonged illness and had died when he was about fourteen. However, he had failed to get good marks in school even before her death. His problem of education (intelligence) was linked to a feeling of unworthiness related to guilt over his relation with his mother. The group did not react to his complaints about his lack of education, but to his sense of inadequacy, of not belonging, and of guilt toward his mother. These problems they saw as similar to their own.

Hurford, a peripheral member of Dr. L's Group, had had much less education than most of his fellows. He customarily avoided any discussion of his emotional difficulties, and at the present meeting, when other patients questioned him about his problems, he indicated that he didn't like "to hash them over." When they insisted that he would feel better if he talked about his difficulties, Hurford brought out that he liked to talk about "good" things in the group but didn't want to talk about the things he disliked about himself. He blamed his failure to achieve much in life on his lack of education—which he appeared to use as an excuse for his sense of failure.

Other group members reacted to this as both a reality and an emotional problem. They pointed out that even now he could go ahead and get a better education, and he acknowledged that he could and would hate himself if he didn't. One of the professional men said

that he had thought that an education would be the answer to his own problems but had found, now that he had an education, that he still had the same emotional problems as Hurford. The discussion later veered toward how money is made, how one gets the things one wants, and how the various patients got what they wanted from their parents. Having begun with education, the discussion ended with its relation to emotional needs.

Throck, a patient in Dr. L's Group who had not completed high school, repeatedly attacked other members on the basis of their superior education. When one patient rose to leave early, saying that he had exams to take, Throck retorted that he, himself, was going to school next year—he was tired of working for a living. He added that he was going to study interior decorating and concluded defensively, "Anybody got anything to say about that?" Throck remained in the group for over a year and a half. His habit of questioning other patients on their intellectual approach to their problems had a therapeutic effect on them. As his own feelings of inferiority and insecurity were analyzed, his comments about educational differences diminished.

In Dr. P's Group 1 differences in education initially presented an important issue, which was resolved at Meeting 3 with considerable benefit. At Meeting 1 Incliffe, who had progressed from college to postgraduate school, remarked that his comfort in the group situation reminded him of his previous successes as a university student leading philosophical discussions. At one point he said to a fellow member, "I won't attempt to argue with you. I don't think you've been around these concepts enough to make it worthwhile. . . . I don't think I'm too well versed in them myself." He told Merrick, who had had a high school education, that the latter's extensive reading was not the same thing as a program of study, and he recommended that Clover, who had also finished high school, go to "one of those fly-by-night mechanic's schools, where they can adapt your previous abilities to a trade." In reply Clover attacked erudition, philosophy, and psychiatry—insisting, "You have to please yourself first."

In Meeting 2, when Incliffe recommended "knuckling down to the problem of getting ahead economically" and added that he'd been pursuing his studies for ten years, Merrick responded, "I feel I've gotten all I want out of school. . . . Some people with masters' degrees don't know what to do."

In Meeting 3 a college student joined Merrick in successfully persuading Incliffe to place more value on enjoying life. At this meeting Incliffe defended reliance on intellect, will power, and "keeping the



mind occupied" as having been necessary in his own case. Later he was apologetic about having devoted years to "scholastic philosophy" and agreed with Dr. P that his feeling of not belonging was responsible for his studiousness. He showed an increasing ability to respect Merrick thereafter.

### *Race, Religion, and Cultural Background*

Differences in race, religion, and cultural background, even when accompanied by considerable mutual antagonism, did not necessarily impede a group's functioning and at times stimulated therapeutically relevant reactions, as in the following examples.

The introduction of two Negro patients into Dr. P's Group 1 did not appreciably affect the functioning of this group despite the presence of two white members from the South, one of them, Stern, somewhat paranoid and openly anti-Negro.

Stern first revealed his irritation indirectly by saying, "What keeps me from coming is not these two fellows"—indicating the Negroes. He then described his difficulties with colored people, concluding that he got no benefit from therapy. One of the Negroes, in keeping with his highly intellectual approach, attempted to reason with Stern but to no avail.

On one occasion, when the Negroes were not present, Stern expressed his feelings of superiority as a white man and then commented: "That gets my goat—colored guys at the record shop where I wanted to work. You have to be smart to do that electrical work; I can't get in, but they have enough brains to get in." Shortly thereafter Dr. P asked Stern whether he resented these men "with intelligence enough to repair radios." Stern, indicating one of the Negro patients, replied, "He makes me feel inferior." Recalling Stern's similar attitude toward Jews, Dr. P asked, "Like the people at the jewelry company?"—thereby bringing out the fact that Stern's prejudices against several groups were related to his feelings of inferiority.

Trippitt, a Jewish patient, in Dr. N's Group 1, complained that he did not know how to remain sincere in the presence of anti-Semitism without provoking a fight. Coombs, who had been educated in a Catholic university and was in conflict about his Catholicism, had denied that he was anti-Semitic. At times, however, other group members felt that he showed some anti-Semitism. In Meeting 60 Trippitt said that Coombs' antagonism to him arose from the latter's anti-Semitism—one of the first times that he had been able to talk back.



At the next meeting Coombs said that he realized this attitude cut him off from people, and that this was why he had felt deeply hurt by what Trippitt had said.

In Meeting 99, when Trippitt talked of expecting a violent reaction if he declared himself a Jew at a party, Coombs said that in a similar situation he had once embarrassed anti-Catholics by announcing that he was a Catholic and then enjoyed their embarrassed silence while he hung his head humbly. He added later that he thought it was bragging when a Jew asserted his Jewishness immediately. Trippitt assured Coombs, "It's not bragging, I can tell you that!" Coombs pointed out that such statements, instead of starting a fight, cast a pall over a party.

Trippitt did not fight Coombs on this issue, but for the first time in the long history of their flare-ups he brought up an objective reason for anger at Coombs. He recalled that two weeks ago he had asked Coombs whether a certain book belonged to him and Coombs had said, "No," although he had walked away with the book—indicating that he had lied. There followed a mutually therapeutic discussion between the two on how each handled his feelings of inferiority—by pretending to be ignorant and secretly laughing at others (Coombs) or by bragging and acting superior (Trippitt).

In this instance the cultural difference helped Trippitt by bringing out the contrast between what people really felt and what he thought they felt and also by eliciting from him a more appropriate form of aggression, which increased his self-esteem and was followed by a better understanding of how he dealt with his feeling of inferiority.

In Dr. N's Group III religion was a matter of therapeutic relevance to Goodfriend, a Jewish patient, who had been hesitant to join because he feared anti-Semitism. When his defensive attitude was challenged by Bridges, there followed a free discussion which had a therapeutic effect on Goodfriend (see Situation Analysis 31).

### *Age and Life Experience*

The following examples illustrate how differences in age and life experience became involved in transference patterns and also seemed to be partly responsible for a helpful modification in the behavior of an older man in one of the groups.

In Dr. N's Group II Coombs, who was 38, tended to be patronizing and protective toward the 23-year-old Ingram. As this attitude was not reciprocal, Dr. N treated the relationship as pertaining only to the

dynamics of the older patient. It appeared that the older man saw the other as his younger brother and behaved toward him in much the same way.

In Dr. X's Group an older, highly successful man named Tile had severe phobias. Expression of hostility had been prohibited in his childhood, and subsequently his inability to express disagreement had hampered his career. Randall, a younger man who joined the group at Meeting 30, reacted to Tile's report of progress in his ability to express anger by ruminating about how he could probably beat up Tile. In an individual session he related this to a growing resentment of his father's bullying. Hastings, a comparative newcomer contemporary with Randall, spoke at length about an older man to whom he used to turn but who had died recently. At the end of the meeting Tile reminded him that the other members of the group were there to help him. Dr. X asked whether Hastings had gotten any relief. Hastings answered "No," and then said to Tile, "You look like that man who died."

Tile reported to Dr. X that his principal satisfaction in joining the group came from the opportunity it provided to be a good father. At first his contributions to the meetings consisted almost exclusively of reports of obstacles overcome in therapy, told with an attitude of encouragement to the rest. Later he reported that the real benefit he had received was what he had learned as the result of a severe setback.

Street, another older and successful man, at first clowning, acted the old codger who was present only to help the others, and joked to relieve tension. When he returned from a six months' absence, the group no longer accepted this role, which he abandoned after first expressing disbelief that he could change at his age. He was helped by a younger man named Cole, who asked reassuringly, "Why do you make fun of yourself?" Street: "I want to be one of the boys." Cole: "You don't have to run yourself down to belong. I'd much rather have you here than Dick or Grey" (two contemporaries). At the subsequent meetings Street participated beneficially in working through conflicts.

#### PATIENTS WHO LEFT GROUPS

The ideal approach to the problem of group composition would be to make a systematic comparison between patients who did well and patients who did poorly in group therapy. But to do this one would have to be able to identify and measure the personal attributes of the patients in each group, the degree to which each patient responded

to therapy, and the distinguishing properties of each group. Since none of these areas can at present be delineated with sufficient clarity to permit a systematic study, the problem of composition is appreciably narrowed by concentrating attention on those patients who demonstrated unsuitability for therapy by promptly dropping out. Thus, evaluation of degrees of therapeutic success can be avoided, and consideration of group properties can be simplified since only a few meetings need be taken into account.

During our period of observation 74 patients left the groups to which they had been assigned. Chart 4 shows the reasons they gave for leaving in relation to the number of months they remained under treatment. Five patients (indicated by cross-hatching) were discharged as moderately or markedly improved—that is, they had reached an agreement with the doctor that they had received enough benefit from group therapy. These patients were in groups led by our two most experienced psychiatrists—4 in Dr. X's Group and 1 in Dr. N's Group II. As 38 patients showing moderate or marked improvement were still under treatment when our study ended, it would seem that the less experienced doctors set their standards too high in respect to discharging patients.

Seventeen patients (indicated by diagonal lines) left groups for such ostensibly environmental reasons as moving to another city or, in a few cases, inability to take time from their jobs to attend meetings. They are classed separately because we could not determine whether their reasons were genuine. We know of some instances in which the real reasons were not stated. In one case the patient wrote from out of town that he had not been able to stand treatment. In other cases leaving town was a sign that the patient had benefited sufficiently to be able to take up a career elsewhere.

The remaining 52 patients (indicated by dots) dropped out because they or their doctors found group therapy unsuitable. All left of their own accord except two, who left at the doctor's suggestion. Almost half left within the first two months. Eighteen patients, or about one-third, left after no more than three sessions. Thirty-one, or about 60 per cent, continued in individual treatment, indicating that they or the doctor found group therapy less suitable for them than individual

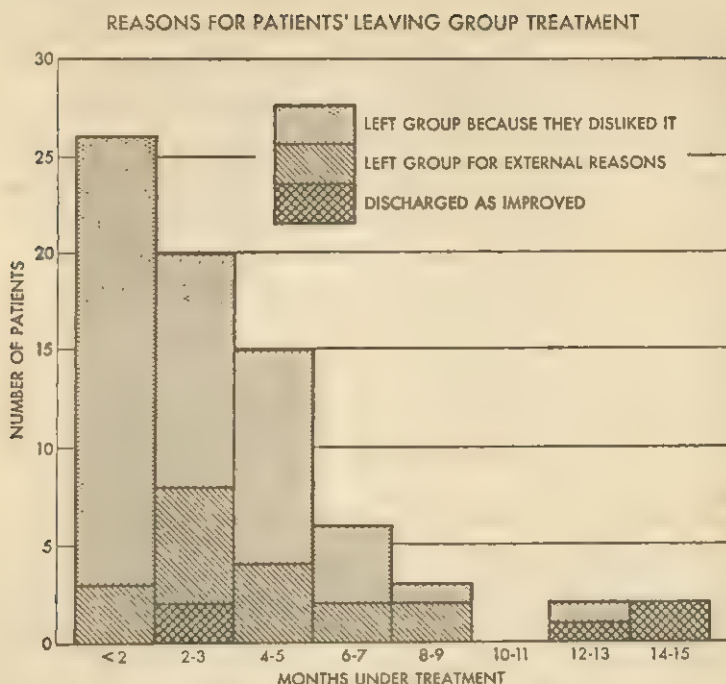


CHART 4

therapy. This figure may be as high as it is because the doctors and the patients were more accustomed to individual therapy, and in each case the patient knew that he could continue with the same doctor if he left the group. This explanation is supported by the fact that of the seven patients who dropped from the two groups composed of patients having only group therapy, only two took advantage of the opportunity for individual treatment with another doctor.

These data suggest that:

1. We may have kept some patients in treatment too long.
2. Patients who cannot adjust to the group tend to leave quickly.
3. Of those who left their groups, about half specifically objected to the group method of treatment and not to psychotherapy *per se*, as they continued in individual treatment. (This may have been largely determined by the particular circumstances of our study.)

A promising approach to the problem of grouping patients would seem to be the study of the psychodynamics and social relations of the patients who dropped out of groups, with respect to the particular



properties of the group which they left. These properties included the doctor's style of therapy and to some extent his personal needs and motives, the nature of the content approved by the doctor and accepted by the other patients, and the presence of patients who seemed particularly threatening to those who dropped out. A distinction was made between groups in which the relationships encouraged by the doctor tended to be primarily patient-to-doctor and those in which the emphasis was on patient-to-patient relationships. No doctor confined himself exclusively to one approach. Each varied his approach from meeting to meeting and even within individual meetings. The distinction was more apparent in the early meetings and might be relevant because over 75 per cent of the patients who left did so within the first ten meetings.

The attributes common to the patients who dropped out of a given group were abstracted from their initial interpersonal-relations interviews and psychological tests and compared with those of patients who remained, in an effort to isolate a syndrome of personality attributes which appeared among patients who left. This syndrome was then sought among patients who had stayed in other groups. The mores and interpersonal relations in the groups which patients left and in the groups in which their counterparts remained were reviewed. Consideration of the differences between the demands made on patients who dropped out of certain groups and those made on their counterparts who remained in other groups revealed certain determinants which may have caused patients to leave.

These steps represent the first attempt to study the relations between group stresses and personality variables which may lead a patient to leave a group. The next step would logically be to see whether a patient who dropped out of one group would stay if placed in another which lacked the threatening features of the one he left. This remains for future research.

For reasons of expediency we decided to study only those patients who continued in individual psychotherapy after attending only a few group meetings.\* There follow accounts of fourteen such patients

\*In singling out for study those who dropped out of group treatment early, we do not imply that all those who remained a long time were properly placed but merely hold that the reverse is true.



in six groups who attended not more than eleven sessions (nine attended five or less) but remained in individual treatment. It may be inferred that these patients were unable to tolerate participation in the group, rather than the therapeutic process *per se*, since all but three of them stayed in individual therapy with the same doctor who led the group. Of the three, one requested another doctor. The other two wished to continue individual treatment with their group leader, but this could not be arranged because the experimental plan excluded individual therapy by him. Consequently, leaving the group could not have been due to inability on the part of these patients to get along with the doctor.

### *Patients Who Left Dr. K's Group*

Boyden, Trill, and Wyman left Dr. K's Group within the first twelve meetings. Boyden and Trill were diagnosed as obsessive compulsives; Wyman as having an anxiety reaction. According to the interpersonal-relations interview, these patients were quite different, except that they repressed their feelings, especially hostility. Issues related to authority were important for all, but each reacted to it differently.

Boyden resentfully referred to his mother as "rather bossy and critical" and to a former supervisor as "too critical" and always "rushing" him about. He was accustomed to leaning heavily on his parents, although he made such remarks as, "My mother wants to keep me a little boy" and "I've got to stand on my own two feet—I'm too much obligated to my family." His reaction was not so much to follow his own inclinations as to avoid doing what his family wanted.

Boyden was reserved but differed from everyone else in the group in that his tests did not indicate marked repression. He was much less responsive to emotional stimuli than either Trill or Wyman, and unlike them he was not overconforming. He showed a sense of inadequacy and some paranoid tendencies and that he felt secure under the protection of large female figures.

Trill was somewhat aware of his hostility, admitting that he was hypercritical and chose only "bookish" people as friends. He said that he had been severely disciplined by his stepfather and that it had done him a "world of good." Although he had been an assistant leader at high school and in the service, as a child he had always been a follower. He consistently sought a "good" authority and was unable to tolerate a slovenly one. Trill seemed comfortable only in situations where the rules of the game were well defined and some single person

was firmly in control. On the tests he seemed to be excessively repressed. He was overconforming and showed a good deal of free-floating anxiety. He seemed to be quite acceptant of what went on around him but actually attempted to control situations by applying rules.

Wyman had isolated himself from early childhood. He had nothing to do with his siblings, preferred to go fishing alone, and during late adolescence would sometimes not speak to anyone at home for two or three days. His interpersonal-relations interview implied a mild rebelliousness toward his boss. At the time of treatment he entered only into very distant relationships. In his tests Wyman showed an intense reaction against authority, a resentment at being dominated, and a tendency to dominate others. This was coupled with anxiety, feelings of inadequacy, and unhappiness. He showed a high degree of accessibility to emotional stimuli, to which he gave way easily. He tended to distort reality and was vague and evasive.

The early discussions in Dr. K's Group had been on an intellectual plane and largely concerned with psychological generalities. The patients seemed to be protective of themselves and toward the doctor; later they tried to outdo each other in self-revelations. Dr. K was rather withdrawn, seemed apologetic when he talked, and bent over backward in his effort not to control the group, although his face often expressed displeasure at abstract discussion and competitive maneuvers. Patient-to-patient relationships developed rather than patient-to-doctor relationships. The patients seemed more or less aware that they were not really getting down to business.

In this setting Trill expressed contempt for Dr. K's weak authority; his need for a strong authority was not being met. He was unable to talk about himself because of his need to feel superior, and he was unable to dominate because of his habit of repression. He left the group after eleven meetings but continued in individual therapy. Wyman came to only one meeting. He seemed more interested in asking general questions about dynamics than in listening to the answers. Dr. K and the other patients urged him to bring out an emotional problem, but in view of his repressed need to dominate, his sense of inadequacy, and pattern of vague evasiveness, the group situation was intolerable.

Boyden initially showed his compliance by doing what he thought was expected in the group—that is, he talked about himself. Being less repressed than Trill and less sensitive to external stimuli than Wyman, he found it less difficult to talk about himself. He failed to receive

adequate support from Dr. K and got a contemptuous response from another patient for his lack of achievement. His participation gradually diminished, and during the last five of the ten meetings he attended he was silent. Afterward he expressed surprise that others were not always helpful. His inferiority was aggravated by the intellectual atmosphere of Dr. K's Group. As a relatively submissive person with heavily repressed rebelliousness, he was ill at ease when he was occasionally questioned by the others. In his initial interpersonal-relations interview he had expressed concern about others' gossiping—this concern seemed to be partly responsible for his silence and his leaving the group. Boyden defined the doctor's function as first of all to keep patients from "deceiving" one another, since they had to be "more truthful" because of what they had told him in individual sessions. In his terminal interpersonal-relations interview he complained that Dr. K "didn't take much part in the discussion." He seemed particularly upset by a patient "who acted as if he were the psychiatrist" and "knew the answers." Boyden ruminated in regard to this patient as follows: "He may have been worse off than any of us. He had that assurance. He was so sure; I didn't feel so sure. He showed a complete lack of understanding. Dr. K told me to try not to let that fellow upset me, not to feel I had to do as he said. He (the other patient) said all I had to do was to leave home, be thrown out on my own, and I would get better. Dr. K didn't say anything (about this) in the group." Boyden clearly felt unsupported either by Dr. K or by the other patients.

None of the patients who remained in Dr. K's Group resembled those who left, except one, who faintly resembled Boyden. This patient, however, lacked Boyden's compliance and was much more detached.

Patients similar to Trill, Wyman, and Boyden stayed on in other groups. Winston, who remained in Dr. L's Group for nine months, was an obsessive-compulsive like Trill and had many traits in common with him—repressed anxiety, sensitiveness to stimuli, overconformity, and passive resistance. Unlike Dr. K, Dr. L was directive and encouraged the expression of the hostility of patients to each other. This situation met Winston's needs and might have met those of Trill.

Ingram, who attended Dr. N's Group II for over a year and a half, was comparable in many ways to Boyden. He was passively dependent on his dominating mother, concealed rebelliousness and other feelings, and was overly concerned about what others might say behind his back. He needed the protection of authority. Dr. N was particularly

solicitous about Ingram, apparently responding to the latter's un-verbalized need for protection; thus, in contrast to Boyden, Ingram had as much support from the doctor as he needed.

Had Boyden been able to satisfy his passive-dependent needs in his relationship with Dr. K, he might have stayed in the group. Had Wyman and Trill been in the group of a more directive doctor, who encouraged patients to express their hostility (instead of in a group in which they had to be solicitous about the doctor and to vie indirectly with one another), it is possible that they might have remained in the group. But a tentative deduction of this sort, of course, needs further validation.

### *Patients Who Left Dr. N's Group II*

Fisca and Mason soon dropped out of Dr. N's Group II. Fisca sought treatment for psychogenic epigastric distress; Mason was referred for psychiatric treatment as an adjunct to medical treatment for a peptic ulcer. Interpersonal-relations interview data indicated that these two patients had several traits in common—a repressed hostility toward wife and boss; an eagerness to make a good impression on others; and a desire to control others that was sometimes rather subtly covered by efforts to please. Both of them maintained only superficial relationships with people to whom they had a slap-on-the-back approach. Both indicated negative feelings about others. Mason called his boss a "slave driver," and Fisca was adversely critical of a woman supervisor as well as of women subordinates.

On the psychological tests these two patients appeared somewhat different. Fisca had few resources, was highly accessible to stimuli, and tended to react in a socially unacceptable or inappropriate and agitated fashion. He had murderous fantasies which alarmed him. He resembled Mason chiefly in his desire for self-control and the control of others, in his low self-esteem, and in his repressed hostility, which was more acute in him than in Mason. Mason had better resources, though he was only moderately accessible to stimuli. Like Fisca, he tried to repress his interpretations, because when he responded he was apt to become agitated.

Dr. N clearly expected patients to discuss their problems and express their feelings. At the first meeting he enumerated various topics about which the patients might want to talk. He responded readily to any patient who spoke of a problem and thus encouraged direct patient-to-doctor relationships.

In his eagerness to make a good impression and to please, Mason



talked at the first meeting of his wife's difficulties and his irritation with them. When Dr. N asked if something else might not have contributed to his marital problems, he became silent. He then lapsed into giving advice to other patients. Repeatedly Dr. N pointed out that giving advice does not help. At least once, he pointed this out directly to Mason. It may be assumed that Mason—needing to control—would have found it difficult to adjust to a group in which, in order to please the doctor, one's own weaknesses had to be shown. After five meetings, when he dropped group therapy for individual therapy with another doctor, he said that certain things were "sacred" and could not be discussed with other patients present.

Fisca attended one meeting at which Dupont, a passive and dependent patient, was the center of attention as he presented his difficulties in regard to masturbation and sexual activity. Toward the end of the meeting Fisca participated for the first time, telling Dupont in very firm terms that his problem was not so much about sex as about guilt over sex and relating this to Dupont's feeling that everything was either completely right or completely wrong. In the tense discussion about sex Fisca had spoken with definiteness and what seemed like some impatience. He came closer to Dupont's problem than any of the others, but Dr. N attempted to counteract his advice-giving because he felt that the problem was not yet clearly understood. Dupont, an obviously passive type, was in danger of Fisca's domination, and Dr. N wished to prevent this. In view of Fisca's hostility, especially toward his boss, one may surmise that he was angered by the doctor's rejection of his advice (which showed acute insight and pleased Dr. N, although he did not show it). The consequent threat to his self-control, combined with his loss of face in the group, made the situation intolerable. The subject also may have been upsetting because of his hostility to women. In subsequent individual therapy Fisca told the second doctor, "I don't like to tell others my business, and listening to others' problems doesn't help me. Some subjects and opinions were frankly upsetting. I might get to the point where I'd blow up and argue with them."

No other patients in Dr. N's Group II showed this same cluster of characteristics, though certain patients had one or more of them. Thus Veal, who most closely resembled Mason and Fisca, seemed accessible to stimuli as did Fisca, but he responded by withdrawal. In his interpersonal-relations interview he said that everyone was "very nice" and made no critical or hostile comments. Flower revealed negative feelings toward situations but never toward indi-



viduals. While Bly and Thomas were as dominating as Mason and Fisca, both of the former showed great resources and their responses to stimuli were almost always appropriate and socially acceptable.

Patients very similar to Mason and Fisca stayed on in the same doctor's Group III (pp. 99-101). Like Mason, Minor showed a desire both to control and to please and a repressed hostility to superiors. Goodfriend was a counterpart to Fisca in his excessive hostility and fear. He, too, was critical of his wife and tried to make himself acceptable to others and to control them by giving advice. Yet both Minor and Goodfriend remained in this group.

The explanation may lie partly in the fact that Dr. N had had a year's experience or more when he undertook Group III. Moreover, considerable study had gone into the composition of Group III and into the techniques that the doctor might use. The initial meetings of these two groups were quite different. In Group II the patients asked for leads and Dr. N suggested possible problems in connection with hostility, mothers, women, work, and service in the Armed Forces. He encouraged patient-to-doctor relationships and pointed out that advice-giving was unprofitable. In Group III Dr. N was much less directive; as a situation arose in the group, he would examine it with the patients. During the first half of the first meeting, after a few introductory remarks, he made no comments while Minor, Goodfriend, and other patients questioned and advised a fellow member. He was genuinely acceptant of Goodfriend's opening hostile comments. Unlike Mason, Minor had repeated opportunities in the group to give advice. In Group III there seems to have been a balance between patient-to-doctor and patient-to-patient relationships, a preponderance of the latter perhaps being encouraged initially. Dr. N exerted no pressure on the patients to talk about themselves. These differences may explain why Minor and Goodfriend remained in Group III and Mason and Fisca left Group II.

### *Patients Who Left Dr. P's Group I*

Cook left Dr. P's Group I after attending Meetings 1 and 4. Clinically he was diagnosed as a neurotic with obsessive-phobic reactions. Data from the interpersonal-relations interview indicated that he was hostile toward his father and felt superior to and isolated from him. Although he had superficially friendly feelings toward workmates and boss, he also felt isolated from them. He felt rebellious toward his mother but close to her and also to his siblings. He tended to inhibit his feelings but was able to relate with some affect to the woman

interviewer, whom he tried to dominate. Psychological tests indicated that he was overly neat and fussy and preoccupied with details because total situations were full of danger for him. He was verbally facile, yet somewhat repressed. He showed a stubborn argumentativeness and impulsiveness when challenged. Frequently he seemed to be trying to prove himself a man. In summary, Cook might be characterized as an obsessional person, insecure in his relations with both superiors and peers, who met his anxiety by an air of superiority and an attempt to control or dominate others. He tended to inhibit his feelings, but gave way to impulsive outbursts when challenged.

At first members of the group advised one another about vocations, self-confidence, and sex. The doctor did not participate and patient-to-patient relationships developed. Cook was comfortable in that he could assume an attitude of superiority. He bragged, gave advice, and at one point explained another patient's problems to the others.

In the fourth meeting Dr. P was more active, and his interventions were of the sort that tended to encourage patient-to-doctor relationships and to diminish the opportunity of one patient to dominate the others. As the discussion progressed, the doctor re-stated the problem to facilitate interpretation. When Incliffe questioned Cook, Dr. P cut in, thus preventing Cook from acting superior. At the end of the meeting Dr. P questioned Cook's ability to accept his sex drive, thus threatening to expose Cook's self-doubts in front of the group. Cook did not return to the group after this meeting, although he continued in individual therapy for some time. The threat of exposure before his peers did not exist there.

Of the four other patients in the group, all of whom remained, only one, Incliffe, diagnosed clinically as a schizoid personality, revealed a pattern that was at all similar. He, too, had a need to maintain an air of superiority with his peers, but he made less obvious attempts to control others—his pattern being rather that of a self-controlled pedant. All the other patients had less fear of dependency and could therefore be comfortable in a situation in which the doctor played an active role.

That Cook's failure to remain in group therapy may not have been due to his personality attributes as such, but to their interaction with this particular group, was indicated by the fact that Charles, a very similar patient, remained in Dr. L's Group for over a year and a half. Like Cook, this patient needed to dominate the others and yet maintain superficially friendly relations with them. He, too, had a superior air and seemed to be trying to prove his manhood. He had an ob-

sessive-compulsive character and was verbally facile, although somewhat repressed in certain areas. Hostility to father and rebelliousness toward mother were present in varying degrees in both patients. Charles was isolated from his father and his schoolmates. However, where Cook was blatant and impulsive, Charles was subtle and seductive, seeming on occasion to be able to accept the dependency on his peers which Cook was afraid of but secretly desired.

Since the attributes of the patients in Dr. P's Group were quite similar to those in Dr. L's Group, the factor chiefly responsible for Cook's leaving Dr. P's Group, while Charles remained in Dr. L's Group, would seem to have been the difference in the styles of the two doctors. Dr. P made interpretations directly to individuals in the group and found it difficult to tolerate the growth of patient-to-patient relationships (see the section on doctors' problems below). It may be that Dr. P's technique fostered a dependency in his patients, which Cook could not tolerate in the presence of others, as it might cause him to show weaknesses. Moreover, Dr. P's pointed questions may have implied too great a threat of exposure; he commented as follows on Cook's dropping out: "He strove for status and the doctor defeated him in this, thinking that the patient was speaking unrealistically."

Dr. L, on the other hand, encouraged patients to establish some sort of "transference to the group" and to work on their own problems with one another, not addressing themselves to the doctor or seeking answers from him. He made this clear, being quite directive about turning the patients' questions back to the group. He allowed patients to relate to one another on their own terms, so that they felt no danger of premature exposure.

### *Patients Who Left Other Groups*

The preceding discussion of patients who left a group illustrates our method of studying the problem. Similar detailed study of all patients who left groups would be too lengthy for this work. The following is a briefer review of relevant data about some patients who left other groups. In each case a counterpart stayed in another group.

In Dr. X's Group each patient was called on to report his daily life and his progress in therapy. Dr. X was directive in fostering relationships between himself and the patients rather than relationships among the patients; he pointed out the similarities between patients but did not encourage patients' discoveries of one another. Doon and Janeway dropped out of this group. Doon was an alcoholic, and so

presented special problems which were not included in our study.\* Janeway, who attended four sessions, was an obsessional patient with a psychogenic backache. Psychological tests showed that he characteristically used composure as a front and, when this defense failed, tended toward tantrumlike irritability. Since the group was well organized when he entered it, Janeway remained rigidly outside. He boasted of his intellect and his skill at exploiting people, emphasizing his uniqueness and attacking the purposes and mores of the group. He defended the reasonableness and value of his defenses. The other members disliked his erudition and his unwillingness to consider himself responsible for his difficulties. When Dr. X questioned Janeway's attacks, he responded aggressively, avoided expressing emotions by generalizing his feelings, and pedantically tried to control the situation. He was frustrated in this by Dr. X's active direction of the group. The fact that his defenses were so unacceptable to this doctor and this group may have contributed to Janeway's early departure.

Three men left Dr. Z's Group—Reiser, Rosen, and Olem. Reiser, an inadequate personality with paranoid tendencies, attended only the first three sessions. At his own request he continued in individual therapy with another psychiatrist of the clinic. Rosen, who was diagnosed clinically as an obsessive-compulsive neurotic, entered the group at its second meeting, attended five out of the first nine sessions, and then broke off treatment. He later returned to Dr. Z for individual therapy. Olem, a schizoid personality with depressive tendencies, attended eleven group sessions. He then left the group but stayed in individual therapy with Dr. Z.

During the first few meetings of this group Dr. Z participated minimally. He reported that he tried to keep a "professional and serious aura" about the meetings and did not want the patients to consider him "one of the gang." He remarked that he was "afraid to say something to any one man, as it might seem too significant." This attitude indirectly promoted patient-to-patient relationships; his interventions tended to be generalizations linking the statements made by two or more patients.

Reiser had a great deal of social facility and poise and an apparently impenetrable cover for his difficulties. At no time did he reveal any weaknesses. At the first session he became a protector of the very

\*As previously explained (p. 67), we feel that it is inadvisable to combine alcoholics with non-alcoholics, but evidence that alcoholics may respond well to group therapy of an analytical type has been presented by Pfeffer and his co-workers.<sup>5</sup>



dependent Olem and vied with another patient for the dominant position in the group. At the second session, obviously top dog in the group, he complained that Dr. Z was not giving them enough Freudian interpretations. Dr. Z remarked they had better work on their problems without being too concerned about the use of psychological language. At this meeting, Rosen, who had had previous individual therapy in another city, began to show his familiarity with psychological concepts and quickly won the open respect of another patient. Rosen also gave advice to this patient. Gradually Reiser retired to the background and at the third meeting, his last, remained completely silent, looking quite bored.

Rosen stayed in the group until he had "a few bad weeks." He explained that when he was not feeling too badly he could talk with the other patients. "I could measure my progress. They were still sick, and I was better—I was pretty much at ease in the group being the top man saying the most important things." But when he felt worse, it was a relief to leave the group. He thought that he would have gone backward if he had had to continue. "If I'd felt better, I would have come running to the group, saying, 'Let everybody see this boy!'" In his terminal interview Rosen remarked that he felt Dr. Z had kept pretty much in the background and that there were moments when patients even forgot he was there. Some of the patients, he said, had talked well in the group merely because they wanted to make a good showing in front of Dr. Z. Rosen would have liked to show up as the most important and intelligent, the keenest analyst and the finest patient in the group in order to prove that the other patients were "just a bunch of sticks." "(Dr. Z) left me on my own," he said, "but I didn't have the privilege of being the only one there, and there was no particular path to go on." Initially somewhat anxious in his uncertainty of what would be "expected" of the patients, he soon became comfortable when he saw they were "all in the same boat." "After a while," he said, "it became sort of ridiculous, because the others couldn't swim well either."

Reiser and Rosen showed similar dynamics: both felt the need for an active leader in the group, both felt anxious because of Dr. Z's lack of directiveness and tried to take over the role of top man, but both shortly came to feel their inability to remain the leader. Being highly competitive and without direction from the doctor, their anxiety may well have become acute when they lost the position of leadership and the doctor did nothing to relieve it.

Olem was by far the most dependent patient in this group. It was

he whom Reiser "befriended" at the group's first session. When Reiser did not appear at Meeting 4, Olem spoke of his gratitude for Reiser's support. At first quite shy in the group, Olem subsequently seemed to have no qualms about revealing some of the unhappy details of his childhood with a stern father and a harassed mother. He was completely devoid of Reiser's front and Rosen's ability to play at psychotherapy. He felt that he didn't get the support he needed in the group, and like Reiser and Rosen felt the lack of directiveness on the part of the doctor. In a terminal interview Olem said that the group was a "flop." He felt himself in danger of acquiring the symptoms described by other patients. He was especially irritated by the patient "who had the world by the throat." "That fellow," said Olem, "thought he knew everything. He's somewhat like my father—no questions asked." After a while he felt that he couldn't get things across and that this left him quite unprotected. He didn't object to this in individual sessions—"If I'm alone, it's different."

There is evidence that of the four patients who remained in this group, two found an actively supportive or protective doctor unnecessary and two felt comfortable in the presence of a passive doctor. Of the former two, one was a compulsive patient whose strong defenses against emotion might have made a doctor's support unnecessary; the other was quite detached and self-sufficient. Of the latter two, one was suspicious of anyone's being aggressive; the other one was frightened by authority figures and found the doctor easier to tolerate in the group than in an individual session. "I'm the child, he's the authority. I'm afraid to be close to him. He knuckles down in the group." He seemed content that the doctor had "listened" to him. He also seemed to derive support from another patient in the group who put his interests "in front" for him.

Three patients left Dr. L's Group after attending one meeting but continued in individual treatment. Connor, a schizoid patient with severe headaches, was present at Meeting 1 and described his problems in the Armed Forces, when Dr. L requested that each of the patients tell about his military experience. He was met with derision by some of the other patients, left the group early, ostensibly to meet his wife, and did not return. Soon thereafter he gave up individual treatment and two months later committed suicide. Connor was the only patient who did not establish even a superficial relationship with another patient, and Dr. L did not encourage relationship with himself, since he did not participate after making a few opening comments and suggesting a topic for discussion. When Sleich, a patient with an

anxiety reaction, entered the group at Meeting 5, Dr. L was complaining of the lack of progress, and the patients were defensive, hostile toward one another, and trying to comply with the doctor's somewhat vague criticisms. Sleich made no response when invited to speak midway through the meeting; he remained silent until the end of the meeting and did not return to the group. In a subsequent individual session with Dr. L Sleich described how terribly under pressure he had felt. Part of his problem was anxiety about having to expose his homosexual fears in the group. His relationships in non-therapeutic groups were inadequate.

At Meeting 6 Dugan appeared to be in an anxiety state. He came late, made no spontaneous comment, and when questioned by another patient replied that he "had nothing to say." He did not return to the group and was irregular in attendance at individual sessions. Dugan seemed unable to express aggression. If he was dissatisfied with a co-worker, he assumed the co-worker's share of the job plus his own and did not speak up about it. After attributing his withdrawal from the group to his relative lack of education, he came closer to the real reason: "I know I just never felt I wanted to go around analyzing someone. I guess that is the only way to do it, to have someone tell you where you are wrong. But. . . ." Flushing with irritation he added, "There was one fellow who told how he hated his mother. I didn't want to hear his personal troubles, and I wouldn't want to tell mine—that is, in a group. I guess there isn't anything more."

The three who left Dr. L's Group seemed much in need of a kind of support from the doctor that Dr. L did not offer to any individual patient. Instead he permitted the group to develop a sort of adolescent gang relationship with hostile undertones that were later aired. The group gave little support to anyone who could not hold his own. It seemed as if the patients had to be able to form relationships with each other—often initially hostile—if they were to remain.

In other groups patients who feared self-exposure remained and eventually talked about themselves and analyzed their problems, while the more hostile and aggressive patients dropped out of the group—for example, Janeway in Dr. X's Group and Fisca in Dr. N's Group II. Both these patients were in groups where doctor-to-patient relationships were fostered, rather than patient-to-patient relationships, as in Dr. L's Group.

Consideration of these fourteen patients, supplemented by review of the remaining sixty patients who left groups, permits the tentative

conclusion that the main factor in determining whether a patient dropped from a group was low tolerance for the qualities of that group—qualities which did not make for excessive tension among the patients who stayed on. That is, while certain types of patients seemed apt to leave certain groups, similar patients remained in other groups in which the mores and modes of relationship were different. For example, of the fourteen patients, all five who were passive, dependent, and unaggressive (Trill, Boyden, Olem, Sleich, and Dugan) dropped out of groups in which the doctor failed to offer active support. Similar patients remained in groups in which the doctor was more supportive. In those groups in which the atmosphere was relatively free, some of the patients who left seemed especially concerned about impulses or characteristics of which they were ashamed (e.g., Mason and Jane-way). They feared that these might be brought to light in front of their peers. Such patients gave advice to others, asked for guidance from the doctor, or remained silent but never presented their real problems. Some feared that they might be stimulated to the point of losing control by the attitudes or remarks of others (e.g., Fisca) or that they might pick up symptoms from fellow patients. Others refused to consider the relevance to their difficulties of any life experiences earlier than their battle trauma, as if to do so would be an intolerable admission of weakness.

Many of the patients who left groups were rigid—that is, they were unable to adapt their behavior to the demands of the group they attended (e.g., Cook and Rosen). In individual therapy, they were not exposed to the disturbing impact of other patients, and the doctors were more able to respect their needs. Some rigid patients, of course, also remained in groups, but their behavior patterns were accepted and their limited tolerances respected in the group they attended.

As would be expected from these findings, a clinical diagnosis *per se* had little relation to whether or not the patient dropped out. The fourteen cases include those with obsessional characteristics, anxiety states, schizoid personalities, and psychogenic gastrointestinal reactions.

We do not imply that all the patients who dropped out of a given group were similar, although they frequently were. Some of them



might have been unable to tolerate a particular group for quite different reasons. In fact, Boyden and Trill, who appeared to be equally sensitive to a particular situational stress, reacted to it in opposite ways.

The results of this attempt to study group composition from the standpoint of patients who dropped out of our groups are consistent with the view that the problem of composition is best approached in terms of the concrete group situation. Despite superficial differences among them, all the patients who dropped from any one group tended to have, in differing degrees, certain conflicts or needs that the doctor and other patients in that group did not sufficiently allay or satisfy. It may be inferred that some of those who stayed were better able to adapt themselves to the group in spite of having needs or conflicts similar to those of the patients who left. Others who stayed seemed to be as rigid, but their patterns fitted in with the mores of the group. Thus, on the basis of our present knowledge, we believe that no generalization can be made about types of patients who cannot tolerate group therapy. The problem, rather, is to determine which kinds of groups are most helpful or most threatening to different types of patients.

## TWO PLANNED GROUPS\*

After about a year's experience we developed certain ideas about composition based on observation of groups that had had difficulty in getting started or had functioned poorly and on the considerations discussed in the preceding sections. We then decided to compose several groups according to those ideas, selecting the members from among patients who were on the clinic waiting list. This, we thought, would be a first step toward testing our methods and systematically increasing our knowledge of the therapeutic process. Our work had included close to a year's study of one group of patients who had received very little concurrent individual therapy or none at all. The progress of some of these patients led us to decide that the patients in the new groups should be limited to group therapy (as long as they remained in the group). This would enable direct observation

\*Major contributor: Henry S. Maas.

of all the therapy received by the patients and would enable us more accurately to study the therapeutic processes and the effectiveness of our selection of patients.

All the patients on the waiting list were asked to see Dr. N (the psychiatrist who was to lead the planned groups), a psychologist, and a social worker. Dr. N offered each patient a choice between waiting some time for individual therapy or receiving group therapy shortly. He made it clear that if any patient wanted to drop out of group therapy, he could still go back on the list to await his turn for individual therapy with another doctor. It was stressed that Dr. N would see patients only in the group, unless there were special indications for individual sessions.

Sixteen patients indicated their willingness to participate in group therapy, and all were acceptable to Dr. N. One of these, who had had several years of unsuccessful psychotherapy, dropped out before the first meeting. The fact that there were only fifteen patients to choose from is a reminder that in an experiment such as ours an unlimited number of clinic patients is seldom available. Our problem was limited to the division of fifteen patients into two groups. To do this we studied collaboratively the information obtained on each patient from clinical, psychological, and social work interviews and made predictions in regard to his initial behavior in the group. The groups were composed and suggestions for the doctor's techniques were made on the basis of these predictions.

There follows a brief description of each of the eight patients who actually came to the groups, synthesized from the psychiatric interviews, psychological tests, and interpersonal-relations interviews. We considered the patients' needs and deprivations in the past and in the present, their major presenting symptoms, and their dominant attitude in work and social situations, past and present. Then, on the basis of their resources, psychological defenses, and behavior in relation to their families and in other group situations, we considered how they would behave as members of one or the other of the two experimental groups to be led by Dr. N (iii and iv).

Akers, diagnosed as having a mild anxiety state, was a 28-year-old plumber, who sought treatment because of moodiness, ideas that

others were picking on him, and a variety of mild somatic complaints. He tended to be aggressive, to seek the favor of anyone in authority and to some extent to identify with him. However, he considered himself a failure in this; he felt very strongly that he was not appreciated by authority and was even betrayed by it. He also felt imposed upon by his peers. His older brother, with whom he used to pal, expected him to do the family chores. When the brother married and left home Akers felt deprived of his companionship and unfairly made responsible for helping the parents.

These patterns seemed to be repeated in Akers' work situation, as he was distrustful of other employees and tended to relate primarily to his bosses, by whom he said he was eventually "kicked around." He felt unwanted and rejected. Akers expressed hostility both directly and by projection, but seemed to be able to relate positively to his wife and children, though he was rather dependent on the former and put the responsibility of managing the finances on her. He was moderately resourceful, rigid, and conscientious. He gave the impression of doing everything expected of him, but actually he did only as much as he wanted. He did not appear to want to offer very much of himself in a relationship.

It was thought that he at first would be compliant in the group, trying hard to do what he thought the doctor wanted, but would later show resentment and might feel betrayed by the doctor if no reward were forthcoming. Since he could not arrange for more than one individual appointment before the first meeting, he was asked to come to the group without further preparation, despite Dr. N's feeling that his rapport with this patient was inadequate.

Alban, a 29-year-old typist, appeared to show an immaturity reaction of a passive-dependent type with schizoid features. He sought treatment for lack of confidence, especially with girls, loneliness, sensations of pressure in the back of his head and other somatic complaints, feelings that people talked about him behind his back, and a tendency to excessive drinking. He was an unprepossessing looking man who spoke rapidly and circumstantially in a weak, inflectionless voice. He lived at home and was strongly dependent on his mother but rebelled indirectly against her and his hostile, domineering older sister by drinking and staying out late. His relations with his father and fellow workers were detached and distant. He sought to allay his social anxiety by laughter and jokes, often at his own expense. He seemed to inhibit any positive expression of feelings but made plaintive, dependent appeals. His strong feelings of inferi-

ority were particularly marked in respect to his masculinity, and he seemed deeply confused as to his sexuality.

On the psychological tests it was noted that he lived in a relatively narrow world and was not easily accessible. He had very few organized defenses against whatever stimulation he felt and therefore showed considerable stress. His defenses took the form of being extremely vague and behaving in an ineffectual and poorly integrated fashion. By making himself an object of attention in this passive way, he could thus overcome his sense of isolation.

Only limited therapeutic goals were envisaged. It was hoped to help him to become somewhat more comfortable in his relationships with others, to overcome some of his feeling of uniqueness and possibly to develop some feeling of adequacy. It was predicted that he would stay in an analytical type of group only on the basis of dependency on the doctor and that overtly aggressive men would probably drive him from the group.

Bridges, a 26-year-old salesman who looked much older than his years, was referred for treatment because of violent headaches, nervousness, and excessive fatigability dating from a severe concussion sustained in combat. Neurological and psychological studies showed no organic damage. His condition was diagnosed as an anxiety state. He was competitive, had a blustering manner, and spoke with considerable force and rapidity. He seemed to have great difficulty in showing any weaknesses. While constantly asserting that he could not be dominated, he often indirectly appealed for help, chiefly with a barrage of challenging questions. This conflict between desire to dominate and dependency strivings was plain in all his attitudes.

He sought the favor of the authority figure, identifying with him and seeking social relations with him as a way of denying inferiority, and also appeared to need acceptance from his peers, with whom he was boisterously gregarious. He seemed well able to tolerate tense situations with aggressive people. He felt close to his wife, children, parents, and boss, although not to fellow workers. He was inclined to be hostile and rebellious toward his overprotective sisters and mother. He did not express his feelings about his father. With his wife he was irritable as well as affectionate but expressed only love toward his children. He tended to talk in platitudes that glossed over his feelings. His competitiveness was shown in his enjoyment of selling, which he regarded as a contest with the buyer. When he made a difficult sale, it was a victory over the buyer. He still resented his failure to become an officer during the war.



He was quite repressive and repressed, seeming to fear affective experiences. He showed poverty of ideation, which he attempted to conceal behind vague generalities. These defenses seemed inflexible and discouraging to him. His dominant attitude was one of passive rebellion against having too much expected of him. Demanding of himself the success that his father had missed, he suffered from a constant fear of failure. When challenged, he had a tendency to go to pieces. His problems seemed to revolve around the conflict between his dependency needs, probably greatly increased because of his traumatic war experience, and his desire for emotional emancipation from his parents.

It was predicted that he would attempt to dominate the group by a flood of speech—offering advice to others as a demonstration of his superior competence but revealing little of his own problems.

Cann was a 28-year-old graduate student who had been diagnosed as having a psychogenic gastrointestinal reaction. He had a pleasant, though tense manner, smiled nervously, and showed marked verbal facility. He was referred for severe diarrhea, presumably of emotional origin, but he regarded his uncontrollable jealousy of his wife as his main problem. This was expressed during drinking bouts by morbid curiosity about her previous relations with men and violent attacks of rage. He also complained of nervousness and irritability with his mother and brother.

There was evidence that he had been the good boy at home, concealing his feelings except for occasional outbursts. Yet his mother often told the patient that he was like his unstable father, who had been dead for several years. She showed preference for a less-well-behaved brother and urged the patient to make allowances for him. This he deeply but secretly resented. In childhood he had resented the families living nearby who were better off financially, and at school he had been particularly resentful of teachers' pets.

Cann seemed compliant toward authority and disregarded the reactions of peers. At graduate school he spoke directly to the teacher, with little regard for the other students. In the Armed Forces he had been on good terms with the officers. His friends were all deviants in some way and classed by him as intellectual. When he was critical and resentful of certain people he indicated that they were also disliked by others. His goal was to be a university professor. His stress on intellectual associations and achievements was a recent development and seemed to be a reaction against having behaved stupidly during his school days. He was overcritical of himself and others.

Cann had a fairly good capacity for fantasy and creative thinking, but his ineffectual defenses against extremely high susceptibility to stimuli resulted in uncontrolled outbursts of temper. He seemed to be projecting his unresolved hostility and jealousy from his mother and brother to his wife.

It was predicted that he would participate blandly and skillfully in the group, but that, while speaking freely of his problems, he would tend to seek the doctor's attention and to ignore or adopt a hostile attitude toward his fellow members. There was some question as to the extent to which he would try to control the situation and as to whether he would be threatened by a permissive atmosphere, because of his fear of his own emotional outbursts, but it was thought that his detachment from his peers would be sufficient protection against their angering him unduly.

Goodfriend, a 36-year-old mechanic, was referred to the clinic because of pruritus ani. He complained of fatigue, extreme irritability toward and sexual difficulties with his wife, and constant fears of persecution as a Jew. He believed the only solution to this problem was to build himself up physically by will power. He was extremely tense and somewhat distrustful, abrupt in speech and gesture and avoided disturbing questions by evasive generalities.

He had a "mannish" mother who had supported him and his "rugged, smarter" brother from the time of the father's death. As the family was very poor, he had grown up in a city slum, which was related to his fear of persecution. While in the service he had married a woman whom he described as rather bossy and resistive to his sexual advances. He found security, in a world perceived as hostile, by submissive relations with female authority figures or male peers. But when sooner or later they became too critical of him, he might have an outburst of temper (e.g., at home with his dominating wife he suddenly threw a glass across the room). He showed no genuine friendliness to anyone, but was suspicious and doubting and always on the alert. He was afraid of bosses and resented foremen for their air of superiority. In early adolescence and during his military service he formed dependent relationships with non-critical male peers who were more aggressive than he and showed a solicitous interest in him.

On the psychological tests he tried to inhibit his response to stimuli. He seemed to feel bottled up and frustrated because of his need to "keep the brakes on" his strong inner pressure. His defenses included vagueness of response and avoidance of becoming involved in any way.

In short, he had intense, thwarted dependency strivings, leading to much repressed hostility, to which he over-reacted by his emphasis on will power and self-reliance. However, it was promising that he was dissatisfied with his low level of efficiency and marked discomfort and tension, was emotional and responsive, and had the potentiality for steadier and more practical intellectual functioning.

It was thought that at the first meeting he might be anxious about defending himself in the group situation and that he would assume a wait-and-see attitude, hoping doubtfully for the doctor's protection.

Minor, a 26-year-old salesman, was diagnosed as having a moderately severe anxiety state with obsessional features. He had been referred for severe functional epigastric complaints. He also complained of jitteriness, insomnia, and a tendency to stutter. He showed marked tension and overeagerness to please, coupled with continual self-reproach ("I hate myself").

At home, in the service, and at work, he showed repeatedly the following pattern: He felt that the authority figure was holding him responsible for making a success of any project. He took inappropriate and excessive responsibility and secretly resented it. He feared failure because he felt that he was exceeding his capacities in assuming such responsibility and constantly checked on himself and his subordinates. Although he felt that his activities attracted and pleased the authority figure, he was concerned lest his peers should dislike him for them. To avoid this he sometimes tried not to appear friendly to the authority figure or used similar devices. However, he seemed able to tolerate hostility from his peers as long as he felt that the authority approved of him. He felt that a job had to be well done, but would not be, unless he supervised it closely. While trying to dominate others and secretly resenting their lack of cooperation, he also tried to avoid displeasing them. He usually felt that he was not appreciated. He counteracted his own hostility by describing others in exaggeratedly favorable but meaningless terms (e.g., according to him everyone was "wonderful").

He was the eldest boy in a large family and at an early age had felt called upon to take on the paternal role. He thought that he was the mother's favorite because of his behavior. When two of his siblings expressed resentment of his position with her, he called his mother's attention to their virtues. As a responsible non-commissioned officer, he would repeatedly check on the work of the men under him, incurring the displeasure of most of them with considerable discomfort to himself. He requested a transfer from his first outfit, which was

wiped out in action almost immediately thereafter. He blamed himself for the death of the non-commissioned officer who had changed places with him, and the second outfit also blamed him for it.

On the psychological tests his responsiveness to stimuli was usually repressed but sometimes vague or explosive. He indicated a rather distorted picture of what was expected of him and seemed to be trying to get as many cues as possible from the psychologist, who was an authority figure to him, by stressing his own weakness and inability to do what was asked.

His central problem seemed to revolve around strong doubts of himself and self-hate, which were probably based on hostility to his family and which he tried to overcome by perfectionism.

It was predicted that he would probably not be able to bring himself to join a group, and that if he did join he would not be able to show his feelings for some time. It was also believed that if he did join he would assume responsibility for the meeting's success and feel compelled to make a good impression on both the doctor and the other members.

Small was a 35-year-old salesman who was diagnosed as having a psychogenic gastrointestinal reaction. His main complaint was a feeling of excessive tightness in his stomach with anorexia, tremulousness, and irritability. He returned to the clinic at the suggestion of a Veterans Administration rating physician two years after a year's unsuccessful psychiatric treatment.

He had been more or less on his own from early adolescence. His parents had cared for him only intermittently, the burden falling on relatives. He was very dapper, extremely tense, and spoke in a low voice with a clipped accent, occasionally smiling wryly. His general attitude was that of bitter, half-humorous resignation in the face of insuperable problems centering on his marital situation. He freely expressed doubts that psychotherapy could help him. He seemed fearful of discovering his own weakness and reacted by maintaining an air of superiority. He said that he expressed his anger by remaining silent. He had friendly but superficial relations with his male fellow workers and subordinates, his hostility being primarily directed toward women because of their identification with his mother and his contempt and resentment toward her. Although his hostility seemed close to the surface, he could not accept it. He did, however, enjoy tension and violence and seemed able to tolerate aggression in his associates and his wife. He was competitive and sought the favor of, and to some extent identified with, authority figures but always felt



insecure about their acceptance of him. He lived in dread of being fired in spite of steady advancements and reacted by overworking.

On the psychological tests he showed a well-organized versatility. He was quite accessible to stimuli and showed a fear of loss of control, which he guarded against by conventional behavior.

His central problem seemed to be one of unsatisfied dependency needs and hostility, which he covered by a superficially "hard-boiled" and superior attitude, and by strenuous and successful work.

It was thought that he would maintain a sarcastic, superior "show me" attitude in the group and would be reluctant to discuss his problems.

Stone, a 26-year-old student who sought treatment for intense hypochondriacal fears, difficulty in concentration, and nervousness, was diagnosed as having a phobic reaction. The only personal problem he even hinted at was fear of getting "entangled" with women.

The only possibly significant historical data elicited were that his family were quarrelsome, that he was jealous of and felt inferior to a brother who excelled him in athletics and studies. He showed a generally submissive attitude toward his parents and other authority figures. He strove for acceptance from his mother and teachers, but his attitudes toward the former were conflicting. Practically the only person from whom he did not feel isolated was his brother. His manner was very deferential and cooperative. He seemed to desire to give the right answer. In social situations he gave evidence that he tried to get others to do what he felt was expected. He showed a general inhibition of emotion, except that he expressed contempt and hostility for subordinates, toward whom he behaved in a dominating fashion. When he was angry, he said, he would go off and "think it out" of his mind. He showed no sense of humor.

On the psychological tests Stone also failed to give very much of himself. His productivity was meager. He seemed rigidly to divide people into two categories: those who were perfect and those given to the expression of unpleasant emotions, such as anger and jealousy. He put a premium on not expressing feelings, on being calm, placid, and rigid and on maintaining this front at the expense of close relationship with others. He aimed at being the epitome of conformity.

It was thought that his cooperation in a group would be superficially good, out of deference to authority, but that he might try to divert discussion if it approached his personal problems.

The data on these eight patients and the seven who did not come to group therapy were studied collaboratively with such points as

the following in mind, in respect to group composition and other problems with which the doctor might be faced.

1. In planning the composition of our two experimental groups, should we select patients who were homogeneous in certain respects? If so, what aspects would offer the best criteria of homogeneity?
2. If any two or more of these eight patients were placed together in a single group, would they become too great a threat to one another or would communication between them be too difficult? In this connection who were the patients with sufficient ego-strength to tolerate membership in the same group with exceedingly aggressive patients without becoming so anxious that they would have to drop out?
3. Were any of these patients likely to lead the way for others by demonstrating the therapeutic approach? Were there differences among potential leaders to be considered when placing any one of them in a given group? Would the amount of anxiety that might be aroused in such a patient be intolerable if he were not allowed to be the leader? If two such leaders had to be placed in a group, should we expect the development of a destructive kind of rivalry that might be beyond the doctor's capacity to handle? Singling out such patients was a first step toward investigating these questions.
4. Which patients would be most likely to rush in with self-revelations without regard to the reactions of other patients and before any group support had developed? Such patients often speak explosively out of great internal pressure and then withdraw. Might putting two or more of them together ease the burden for each or make it worse? Could the doctor slow down their revelations without increasing their anxiety?
5. Which patients had defenses that were strong enough to keep them from speaking of their problems of their own accord but brittle enough to be broken down prematurely by group members or the doctor? Ought all the patients with a "brittle front" to be placed together in a single group, or should they be distributed?
6. In regard to the above questions, what should guide the doctors' choice of techniques in the two groups? To what extent should composition of the two groups hinge on the special competence and

limitations of the doctor? Might the doctor, prepared with predictions on how the patients in a given group would interact at their first few meetings, be able to plan his therapeutic approach with greater effectiveness than if he had not considered possible interactions before beginning therapy?

We decided that it would be premature to try to consider which types of patients might facilitate therapy for each other, since up to this point our data had yielded much clearer information on what worked badly than on what worked well (e.g., a dominating and authoritarian patient might form a mutually comfortable relationship with an exceedingly submissive patient, but this in itself might impede therapy). Hence, we did not try to think in terms of which patients might make things initially comfortable for one another, but rather we tried to avoid placing together such patients as might initially react so negatively to one another that the doctor could not deal with the situation therapeutically. Moreover, we thought not merely in terms of one patient and another patient, but in terms of many patients together. It will be noted that we did not consider such variables as age, intelligence, and clinical diagnoses, because previous experience had indicated that they were irrelevant within the range of our patient population.

The properties of these fifteen patients which seemed especially relevant in the light of such considerations included the extent to which they were openly aggressive or competitive with peers, the extent to which they appeared able to stand aggression directed toward themselves, and their ability to expose their own weaknesses. These attributes are summarized in Table 6.

We decided to make the two groups as contrasting as possible with respect to these attributes in the hope of casting light on how grouping affects the nature of the doctor's interventions, the type of group mores which develop, and the therapeutic course of patients.

We first placed together in Group III Akers, Bridges, Minor, Small and Plux, all of whom were openly competitive or aggressive, could withstand aggression from others, or at least gave no evidence of being unable to withstand it, and had difficulty exposing their own weaknesses. With some misgivings Goodfriend was included in this

TABLE 6. Summary of Certain Attributes of Patients in Dr. N's Groups III and IV

	<i>Openly aggressive or competitive with peers</i>	<i>Able to stand aggression from others</i>	<i>Able to reveal weakness</i>
GROUP III			
Akers	Yes	?	No
Bridges	Yes	Yes	No
Cann	No	Yes	Yes
Goodfriend	Yes	?	No
Minor	Yes	Yes	No
Small	Yes	Yes	No
° (Plux)	Yes	Yes	?
GROUP IV			
Alban	No	No	Yes
Stone	No	?	No
(Camp)	No	No	Yes
(Canfield)	No	No	No
(Michaels)	No	?	?
(Paley)	No	No	Yes
(Peterson)	No	?	Yes
(Potts)	No	?	?

° Names in parentheses indicate patients who did not join groups but were considered in forming them.

group because it was felt that his aggressive, suspicious manner and possible outbursts of temper might prove too disturbing to the patients reserved for Group IV, most of whom seemed unable to handle aggression in others.



Our major concern about Group III was that the doctor might have difficulty in getting therapeutic processes started because of these patients' preoccupation with competitive status-seeking and their reluctance to talk about their weaknesses. We looked for a patient who was apparently able to tolerate the kind of aggressive hostility that we expected and who would also be willing to discuss his problems. In other words, we needed a bellwether who, by his own example, would induce the others to talk and yet would neither frighten them by disregarding their sensitivities nor be frightened by their aggression. It was agreed that Cann could best fill this need. He seemed to show considerable social and verbal facility without being repressive and to be able to talk about his problems without disregard for the sensitivities of others.

The eight remaining patients were all compliant and seemed lacking in competitiveness and overt aggression. These were placed in Group IV.

As we composed each group we also thought in terms of therapeutic approach. In Group III it seemed likely that there would be much initial activity on the part of the patients, who would provide their own impetus and move in a direction more or less of their own choice. If the doctor should ask for discussion and analyses of problems too soon, he would meet with marked opposition and possibly even with flight from the group; these patients would resist interventions that appeared to them as attempts at control. It would be necessary for the doctor gradually to communicate his acceptance of their aggression and hostility. On the other hand, we thought that the doctor would have to be ready to intervene if Cann should attempt to discuss his difficulties too freely before the other patients were ready. He should then make an opening for Cann when he felt that the group was prepared.

As to the techniques for the early meetings of Dr. N's Group III, it was agreed that he should simply mention the names of all the patients present without introducing them to each other. With such a competitive and socially facile group it was felt that even this amount of introduction might not be necessary; the doctor could almost certainly

count on one of the patients to act as "host." In addition, the following general principles were agreed upon:

1. Whenever possible the doctor should keep the focus on the group as a whole rather than on an individual patient, whom the others might attack as the doctor's favorite.
2. The doctor should state impressions rather than ask questions, since patients of the type that were assigned to Group m are apt to be defensive when questioned.
3. If a patient should bring up highly personal material at an early meeting, the doctor would indicate acceptance of it and would convey his familiarity with similar material but would not examine it, since repressed patients might be frightened away by premature discussion. It was suggested that the doctor might refer it to the future, saying, for example, "This is the sort of thing that will come up many times. Perhaps it would be better to discuss it after we know each other a little better." He might then wait until he detected that several patients were experiencing a similar feeling before he commented on it.

This plan took into account the brittleness of the façade of these hostile patients and their probable negative reaction toward any patient who gained the doctor's attention, at the same time indicating how he expected the group to function.

Dr. N opened the first session much as he had planned it. He explained about the observer and the recording machine, and then was silent. Minor and Cann both asked him a question about procedure, to which he replied that they might examine their feelings about the present situation. Since Dr. N took no further initiative, at this point Minor assumed responsibility for seeing that things ran smoothly—as had been anticipated. The patients followed his suggestion that they introduce themselves.

Akers and Minor agreed that they felt much better since they had seen Dr. N individually, but Cann remarked that he had had a rather negative reaction. Acting as though he were the doctor, Minor began to question and prompt Akers but said little about himself. In response Akers expressed hostility toward his boss and Goodfriend mentioned similar feelings toward superiors. Only after Minor and Akers had talked in this fashion for some time, did Cann speak up again, asking

Akers rather acute questions. Dr. N had sat silent and attentive until Akers seemed to run dry. Then he remarked, "Apparently there is only one person here who is not afraid to talk about himself." Cann, who had been sitting by impatiently, immediately spoke of his violent outbursts against his wife. This led the way, as the doctor became more active, for Goodfriend to express his irritations with his wife and for Minor to imply that he had similar feelings, which he controlled by scrubbing the floors violently.

At Meeting 2, at which Small and Bridges joined the others, Bridges noisily resisted talking about himself but repeatedly requested that others discuss their problems. He was obviously argumentative and hostile. Cann took up Bridges' challenge and began again to talk about himself, and Minor, not to be outdone, frankly discussed his family background—partly, it seemed, to set Bridges an example. In this process Minor achieved some insight into his behavior and Bridges disclosed his conflict over responsibility. Small, as had been expected, seemed undisturbed but did not participate. At subsequent meetings, he expressed his fear that if he dropped his defenses there would be nothing left for him to go on. Akers remained silent throughout this meeting; afterward he explained privately to Dr. N that he would be unable to attend further meetings because of difficulty in getting away from work.\*

Attendance of all the other patients except Small was quite regular. The fact that only Akers left up to the time of writing (six months after the group was formed), a record equaled by no other group in the clinic—suggested that we had hit on the proper method of planning of the group and that the doctor's technique had been successful.

For reasons that are not relevant here, Group iv was attended only by Stone and Alban—an unfortunate combination of an authoritarian and repressed patient and a dependent and pathetically clowning one. They made little progress in seven meetings, despite Dr. N's greater activity. Then Stone and Alban were invited to join Group iii, in which they remained; Stone obviously made progress as his attitudes changed but apparently gained little insight. Alban's inappropriate placement in this group was apparent. He held the floor with his dependent appeals for attention and his repetitive complaints about his inability to get dates. He became an object of contempt to patients like Minor,

\*The above material is also used in Situation Analysis 2.

Cann, and Goodfriend, to which he reacted by continuing to describe his failures with girls or petulantly withdrawing, as when, at one meeting, he read a newspaper. The doctor made various attempts to protect him, while pointing out how Alban invited the hostility and ridicule of the group. The reactions of the others were typified by Minor, who complained in the final interview that the doctor had seemed to take Alban's side. This seemed to be an example of a patient's differing too much from his fellows. Alban's need for dependence and attention were too great, and the other patients were too competitive and hostile for the doctor to cope with the situation.

In the main our predictions in respect to the patients' initial group behavior were correct. It was predicted that Minor would have considerable difficulty in showing his feelings but that he would feel responsible for the meeting's success, have a compulsion to make a good impression on both the doctor and the other members. At Meeting 1 Minor solved his conflict by remaining silent about himself but taking over the questioning and advising of Akers. His reserve broke down following Dr. N's mid-meeting comment and the opening provided by Cann. Our prediction about Minor fell short to the extent that we did not anticipate how quickly his compulsion to please the doctor and the other members would lead him into therapy.

It was predicted that Bridges would tend to dominate the group by a flood of speech and advice to the others, while telling little of his own problems. True to our expectations, he tried to demonstrate his superior competence by arguing with all the others over a minor matter and then by driving Cann and Minor to talk about their problems before he mentioned his own. He was as blustering and dominating as we had expected, but since he was among men who were similar in these respects no one was frightened away by his behavior.

It was predicted that Cann would be bland and socially skillful, tending to seek the doctor's attention, while ignoring the other patients. In Meeting 1, after a very brief and direct bid for the doctor's attention, he sat back while Minor pumped Akers; he occasionally threw out a question but did not become self-revealing until after the doctor's intervention in the second half of the session. Then by



his effective narration of the violent episodes which took place between himself and his wife, Cann led Goodfriend and then Minor into presenting similar problems. Superficially at least he was somewhat more considerate of the needs of the others and showed considerably less fear of his emotional outbursts than we had expected. We were correct, however, in predicting that he would be primarily oriented to the doctor.

As we had expected, Goodfriend had a "wait-and-see" attitude. He made no comments until Akers had mentioned his shop experience (which was similar to Goodfriend's) and had expressed hostility toward bosses, with the apparent acceptance of the group, including the doctor. Then Goodfriend expressed similar feelings toward superiors. When Cann later described his own violent relations with his wife, Goodfriend spoke briefly of his difficulties with his wife. At the end of Meeting 2, when Bridges directly called attention to Goodfriend's fighting attitude toward the world, Goodfriend talked at length of his fears of anti-Semitism. In response to the supportive atmosphere of the group, some of his attitude of "can I defend myself here?" diminished and he discussed his difficulties with his wife in considerable detail. But whenever he felt too anxious, he continued to use his habitual defenses—evasive generalities, stressing the value of will power, and giving advice to others.

It was thought that Small would maintain a sarcastic, superior "show me" attitude and be reluctant to discuss his problems. During the first meeting or two he was quite withdrawn, but after repeated interventions by the doctor, who attempted to be supportive, he talked about his difficulties at work and at home. Many of his comments to others were biting and his attitude of superiority was manifested frequently by restlessness, boredom, and non-participation. He eventually admitted that if he dropped his front of aloofness there would be nothing left to support him. He remained the patient perhaps least well integrated into the group.

Akers, as was predicted, was a "good boy," trying hard to do what he thought would please the doctor. He was the patient most available to Minor, who sought out a member who would permit himself to be the subject of questioning and advice-giving. But after half of the

first meeting had passed with him in focus, Akers did little talking. He was late to Meeting 2 and silent throughout it. This was in accordance with our prediction that his resentment toward authority figures for failing to reward his efforts was very near the surface and that he would be angry at the doctor if his compliance were not sufficiently appreciated. When he dropped from the group after Meeting 2, we felt that we had not been able to circumvent this difficulty even though we had expected it.

Our predictions for Alban and Stone were in relation to Group iv and could not be adequately validated because they were the only two who attended. We had, however, anticipated that Alban would require a dependent relationship with the doctor and that overtly aggressive men would probably drive him out. When Group iv was merged with Group iii, Alban remained despite the aggression of the other patients, but we considered that he was a misfit in this group, that his placement had both been harmful to himself and impeded the progress of other patients. In any event he stayed on, and to this extent our prediction was in error chiefly because of an underestimation of the masochistic compulsion which led him to seek ridicule. Stone confirmed our predictions to the extent that in Group iv he superficially cooperated from a feeling of responsibility toward authority but attempted to derail the discussion as soon as it approached his personal problems. When he was placed in Group iii, after brief initial uneasiness he showed a high tolerance for the aggressive and hostile behavior of the other patients—as we had predicted.

In Group iii Dr. N was able to carry out the original plans for his approach, which produced the expected effects with one minor and one major exception. He did not have an opportunity to mention the patients' names at the start, as Minor, true to form, assumed the responsibility of introductions. More important, he was not able to postpone consideration of Cann's personal problems. However, his planned caution here proved unnecessary. He permitted patients to behave as their needs indicated and then intervened in such a way as to facilitate therapy without threatening anyone.

A comparison of the running account of the first meeting of Group ii (see pp. 495 ff.) with the situation analysis of Meeting 1 of Group iii

(see pp. 125 ff.) will indicate how much more successfully therapy got under way in the latter.

In the future composition of groups, we would try to define more sharply and put to more effective use the aspects of clinical evaluation, psychological tests, and social work interviews that we found most helpful for predicting behavior in Group III. We would also take into consideration the doctor's techniques and personal attributes.\*

\*The relation of the leader's characteristics to certain aspects of the structure of small groups has been discussed by Maas.<sup>4</sup>

## CHAPTER V

### *Early Meetings*

---

CERTAIN of the phenomena that we observed in group meetings appeared to have importance for the entire course of therapy. For purposes of exposition we have separated from the rest those which were especially characteristic of the early meetings, but in many respects this division is rather artificial. While the attitudes described in this chapter emerged in the first few meetings and persisted for many months, others that were undoubtedly present during early meetings were not verbalized until the patients were well along in therapy, especially those attitudes involving unfriendly feelings toward the doctor.

The salient feature of the first few meetings of most of our groups was the stress felt by patients and doctors, primarily because of uncertainty about what to expect. It will be recalled that only one of the doctors who led groups was experienced in group therapy and that a few were beginners in psychotherapy. Seminars had been held in which problems were anticipated and solutions suggested, but these solutions remained untried. Each doctor now had many questions in mind about situations ahead and how he would handle them. He wondered, for example, how to give each patient enough attention. How to decide on which patient to focus his attention? What might patients be expected to talk about in the first meeting? What to do when patients talked about topics apparently unrelated to therapy? Should he concentrate on the attitudes of the patients toward him and toward one another or on the material they presented? In other words, the doctor was concerned with fostering the evolution of mores favorable to therapy in an unorganized and undefined situation in which a number of patients were simultaneously demanding his attention; he was



concerned with finding ways of making whatever went on in the group therapeutic. To many doctors, therefore, the first meeting was anxiety-provoking—so much so, that two of our doctors refused to have observers present at the first meeting, though admitting them thereafter.

If the doctors were somewhat at sea, the patients were more so—the degree of their confusion depending somewhat on the amount of previous psychotherapy they had had and the way in which they had been prepared for the group. In general, each patient may be said to have had the following questions in mind:

1. Why am I here? How will this situation help me get well?
2. What do I do here?
3. What does the doctor think of me? How can I best enlist his attention and aid?
4. What do the other patients think of me?

To the patients the doctor represented the nearest thing to a fixed point—at least all had seen him before and knew what he had expected in private interviews. The possibility existed, however, that he might behave quite differently in the group than he had in these interviews and what he had seemed to expect of the patients might also be different. For the rest, each man was surrounded by strangers about whom he knew nothing except that like himself they were veterans, patients at the Mental Hygiene Clinic, and persons selected by the doctor for inclusion in the same group.

Patients aroused anxiety in one another in many ways—for example, as people who perhaps couldn't be trusted to keep secrets, as rivals for the doctor's attention, or as neurotic individuals to be regarded with contempt.<sup>1</sup> On the other hand, as fellow sufferers, they were a potential source of understanding and mutual enlightenment. Patients thus tended to find themselves in conflict between hoping to get relief through participation in psychotherapy (which they usually understood to mean discussing their personal problems) and being afraid to take the risk. This conflict led to the rapid emergence of characteristic defenses.\*

The way in which a patient dealt with his conflicts in the initial group situation depended on his personality attributes, especially his

\*Cf. Appendix A.

habitual ways of perceiving and dealing with unfamiliar social circumstances, and on the objective realities of the group situation as determined by the attributes and behavior of the other patients and the doctor. In the next section certain effects of the doctor's activities on the course of initial meetings are described. Following this, phenomena of initial meetings are considered from the standpoint of the patients. Since both doctor and patients are always involved, some overlapping in the presentation is unavoidable.

#### EFFECTS OF THE DOCTOR'S ACTIVITY ON EARLY MEETINGS

At the first meeting of the group the doctor was the only person who knew all the patients and the only one whom each of them knew. Since he was responsible for the treatment, his attitudes and behavior seemed to have more effect on the development of the early group meetings than any other single factor. The following four summaries of early group meetings, each conducted by a different doctor, illustrate how the doctor's activity seemed to influence the way in which the patients related to him and to one another. The descriptions are arranged by the degree of participation on the part of the doctor, the most active coming first. It will be seen that when the doctor was directive and supportive the patients tended to relate directly to him and to discuss personal material, as they had done in numerous individual sessions, and that when he was not directive or supportive, they tended to become more competitive and to avoid expressing problems which might make them appear in an unfavorable light. The greatest tension was produced when he called for personal material and then showed no interest in pursuing the problems brought forward. The fact that these phenomena regularly reflected the doctor's activity, whatever the composition of the group, suggests that group composition was less important than style of therapy.

##### *Dr. X's Group*

Dr. X was one of our most experienced psychiatrists. His goal was to gain an understanding of his patients' problems through what they said rather than through the attitudes that they displayed toward each

other. In general his own attitude was protective. At the first two meetings of his group he was supportive and directive. The patients who attended these meetings had all had college educations and considerable success in life. Each had had twenty or more prior individual sessions with Dr. X.

Dr. X reported that at Meeting 1 (which was held without an observer at his request) he had dealt with initial uneasiness by making clear that getting comfortable informally together was the first goal. He took off his own coat and gave the impression of feeling relaxed and quite sure of himself. He spoke first of the patients as intelligent men and of a significant success each had had. He then proceeded to call on them in turn to tell what had brought them to a psychiatrist. Each patient spoke at some length of his problems in much the same way as he had to the social worker:

Seven patients came to Meeting 2 with an observer present. Street was the first to speak, with a joke about the possibility of Dr. X having a bottle in his desk. The doctor pointedly ignored this by asking, "Is there anything anybody wants to talk about?" Barnes said that he had been reading a book at the doctor's suggestion and commenced to report on it. Dr. X interrupted to ask how many were familiar with it; finding that only three others were reading it, he said that not enough were familiar with it. He then introduced a new topic by asking, as he looked around the group, "Why do you think you have a neurosis?" Barnes briefly told the book's answer to the question, calling it a conflict. Grey said, "We shouldn't as patients be required to know." Caster said that the cause was more of a "fixation" than a "conflict" and described as a fixed idea his inability to be sure the front door is locked at night. Tile: "It's an uncontrolled thought—an uncontrolled thing."

Moore first asked Dr. X for the answer and then said, "I'll dive in—it's a chronic bad adjustment." Then he reviewed what he said he had talked over with Dr. X in the last five months—juvenile delinquencies, mistreatment of his family, alcoholism, and barbiturate addiction. "I grew up around pool halls. . . . I don't know whether to stand up and face it or marry someone who has nothing. . . . I never got a pat on the back. . . . I don't want to waste your time. . . . I'm terribly selfish. . . . My mother worked herself into an asylum." Speaking more rapidly, he mentioned his unhappy marriages and his trouble with the law, and asked if the group some time would give him an opinion on all of this.

Barnes and Grey in turn described to Dr. X their anger in frustrating

situations. Grey: "What makes me throw my cigarette lighter across the room is a neurosis." Barnes: "The book says that's anger over frustration. . . . You feel like a sap." He then added that he was unable to tell people to go to hell for fear of being punched in the nose. "I see my father in me, of course. I have a great deal of love for my father. Six months ago I couldn't be as abrupt with people as I can today."

Dr. X asked Tile to talk about anger. Tile spoke of his growing ability to express anger, adding, "Dr. X can best state my difficulty." Dr. X said reassuringly, "You're doing well. This is your meeting, not mine." Tile mentioned sensing innuendoes in what people said to him or in how they looked at him. He told about the course of his therapy, in which he "wrote many pages and read all the books Dr. X had recommended." He referred to the difficulties he had described in Meeting 1 and concluded with an account of an incident during which his chief had remarked on his improved ability to take a stand. Tile: "Five months ago I couldn't have talked to you like this."

Grey, the only man who had not been an officer, complained of having to call officers "Sir." The other men offered him reasons for his irritation, and Tile explained that combat conditions require assurance of obedience. Dr. X changed the subject, as he thought the group was not ready to accept Grey's getting angry with them. He asked Barnes: "Does any of this seem related to your childhood?" Barnes reviewed his father's distinguished military career, aloofness of character, and lack of intimate friends. He felt that his father had shown him little affection as a child and had even viewed him as one who might be embarrassing. He began to resent his father when he saw the "beating" his mother had taken. Caster asked Barnes a few questions and then told a very similar story of his life in relation to a father who was a high officer and who gave him no support. He said that he felt his failure as an officer had been related to his inability to make decisions even in small matters because as a child everything he did was wrong in his father's opinion. Then, laughing, he said that it was hard to get the doctor's opinion and that this was helping him to have opinions of his own. Dr. X made an encouraging comment in summary. Caster remarked to Barnes, "My own father parallels yours in many ways." Both men said that their fathers did not know that they were under treatment. Caster complained that any junior officer in the country could come to his father for advice but not his own son. Then he told about standing up to his father once and getting knocked down. When Caster asked the group what to do about his



father, Barnes replied, "You've got an emotional, not a mental problem. I shouldn't advise, but by this time you could be independent enough to lie to him."

Tile then started talking about "dealing with elders" and Dr. X picked out the topic of mothers-in-law from Tile's remarks. Each of the previous speakers talked at some length about marital discord.

Street, who had started the meeting with a joke, continued to relieve tensions by telling in a wryly humorous way about experiences which were humiliating to him and which showed that he was in the same boat as the others. For example, when Grey complained of humiliation as an enlisted man, Street said, "And I was an officer filing papers." Dr. X usually cut these interventions short as being "off the topic."

As already pointed out, Dr. X was supportive and directive. He announced topics, encouraged patients by accepting what they said as worthy contributions to these topics, implied that they need not be ashamed of themselves, since they were all successful people, and diverted attacks made by patients on one another. As a rule the patients spoke either to the doctor or to the group as a whole presenting the same sort of material that they had discussed in individual therapy. They questioned one another politely, as if to find out the similarities which the doctor said would be helpful or to lead up to personal problems. In this group, as compared with those in which more responsibility was left to the patients, there was greater emphasis on relating directly to the doctor and giving him the material he wanted and less emphasis on trying to impress one another. The fact that the doctor himself felt at ease probably decreased the general tension.

### *Dr. L's Group*

Dr. L was less experienced than Dr. X. His goal was to encourage the patients to support one another and to carry on their own discussion, but his technique did not produce the desired effect. His manner was detached and rather set. In Meetings 1 and 2 he repeatedly asked for discussion of service experiences, but when the men complied with his request he either made premature interpretations or showed little interest. As a result hostility developed within the group, and the members tried to cut one another out. The group was composed of patients with a wide range of educational and vocational success,

who had had from nine to sixty-three prior individual sessions with Dr. L.

At the doctor's request no observer was present at Meeting 1 of this group. Dr. L reported that he had been uneasy and uncertain about what to do; he now thought that he had been "much too hesitant." He opened the meeting by saying that the men were there to get acquainted and that he thought their service experiences might offer a common basis. All then discussed their service experiences, especially hostility to officers. The attitude of the group was generally acceptant except for some derision of one patient. At this meeting Throck did most of the talking. His apologies for this were ignored by the group.

At the second meeting, with an observer present, Freedman, Hamling, and Winston came for the first time; Throck, Charles, and Bush for the second time. The doctor's goal was to mitigate the disruptive effect of Throck's continual interruptions. He opened the meeting by suggesting, "We could go on this week and try to learn as much about ourselves as possible." When Charles helped the doctor open windows, Throck said that he felt cold all the time. Dr. L ignored this and asked, "Do any of you have any problems you want to bring up?" Throck: "What kind of problems?" Dr. L: "Anything you want." Throck replied laughingly that he still had a problem going strong. The two patients who had attended the last meeting laughed with him. Throck then repeated Dr. L's request to Winston, and the patients started arguing about who had been longest in therapy and who had benefited most. Dr. L asked the three new members to introduce themselves by presenting their problems. When they remained silent, the three members who had attended the first meeting joked about the fear of expressing oneself. When the doctor continued to request information and Hamling, a new member, offered him a cigarette, instead of complying Bush said, "That's one brand I won't smoke!" Charles interposed dutifully, "We ought to bring up the same things here as in individual sessions." Throck and Bush discussed trivialities; then Throck said to Dr. L: "You're thinking of something to say. Why don't you say it?" The doctor countered by asking Throck why he didn't say what was on his own mind. When Throck responded by presenting a girl's problem, the doctor repeated his request. Throck then told about certain home circumstances to which his gastric symptoms seemed to be related. Dr. L asked, "Has anybody else had a similar experience?" Bush then presented a few symptoms, but Throck belittled them and Charles joined in this. Then, as if he were doing the doctor a favor, Charles spoke of how the group had released

some of his anxieties, and Bush and Throck claimed progress too. Freedman laughed as he said that anger had replaced his fear of talking in this group. Dr. L then tried to bring in Hamling and Winston by saying, "Well, we haven't heard from two members yet. . . . Maybe we could hear from Hamling now." Later he asked Winston, "What can you contribute to this idea of anger and anxiety?" Winston criticized the "rash assumption that all have the same fears." The meeting ended with an interchange between the doctor and Throck, which the former started by reminding Throck that he always interrupted others.\*

Twice during the meeting Dr. L related a patient's physical symptoms to emotions: he related Bush's stomach-ache to his hostility and explained away Throck's sweating hands as a symptom of masturbation. The effect of the first interpretation was an increased effort by Bush to deny the significance of his symptoms. The effect of the second was that Charles made fun of Throck's concern over masturbation, as Bush laughed and clapped his hands.

Dr. L took active leadership by asking for problems and by opposing certain kinds of behavior. He seemed to proffer attention and interest but did not maintain it on any one subject or patient. This led the patients to try to hold his attention, and this in turn may have led to their belittling one another. Their behavior may have been related to the doctor's failure to pursue any subject and to their own fear of exposing themselves in the derogatory atmosphere.

### *Dr. P's Group I*

Dr. P was young and inexperienced. He was eager for his patients to accept group therapy and tended to prescribe it, unless they definitely objected. In preparation he told them that the value of group sessions would be the opportunity thus offered of studying their behavior in a group of people. He said that his own role would be that of a "participant observer" and that he would not introduce topics or lead the discussion but would listen attentively and intervene if necessary to keep the group to its therapeutic purpose. His goal was to get at the patients' problems by facilitating interactions among them.

An observer was present at Meeting 1 of Dr. P's Group 1 at the latter's

\*See Situation Analysis 10.

request. Dr. P was obviously interested but was not supportive or directive. The patients tended to assume the therapeutic responsibility but discussed generalities and related to one another in a competitive way. In prior individual sessions three of the patients had discussed experiences of which they were ashamed and continued to feel that the doctor expected them to reveal such matters in the group, despite assurances to the contrary. The fourth patient was preoccupied with physical complaints.

Dr. P started the meeting by introducing the members to one another and mentioned that two were students. He then said, "You are all my patients; I need say little more except that our purpose is serious." After Incliffe had asked Merrick if he too were a student, the doctor said, "I suppose we might start by each stating what some of his problems are." He was silent for the rest of the meeting, but he seemed deeply interested throughout and tried to support patients when they were uncertain by looking at them understandingly.

Incliffe stated that his problem was to find the right job. Merrick said, "That's mine, too." Incliffe then questioned Merrick about job dissatisfactions and offered explanations of his difficulties. Merrick did not accept Incliffe's explanations, but nevertheless kept on stating more problems, as if he were seeking Incliffe's advice. Kapp stated that the real problem was the art of living, as if to bring the meeting back to a "serious purpose." Incliffe quickly asserted his leadership by announcing authoritatively, "Christ says the Kingdom of God is within us." Kapp appeared distressed as he asked Incliffe, "Are you religious?" and the latter announced that he had often been a leader of discussions like this when studying comparative religion. He then proceeded to advise Merrick of the probable effects on him of his Catholicism. Merrick, competing with Incliffe and Kapp, asserted that experience ("my school") was more valuable than their academic schooling.

Clover was apparently contemptuous of the others. He asserted his practical viewpoint, adding that only his health prevented his going to mechanics' school. In rebuttal of Incliffe's theory that one should plan his life in detail to eliminate worry, he said that this method had aggravated his symptoms. When Incliffe and Merrick discussed reading psychiatry, Clover expressed a scornful attitude toward it and later took a rebellious stand against the Church. As a means of introducing his symptoms, Merrick referred occasionally to the doctor's statement of the group's purpose. When this failed to interest the



others, he asked how they felt about terminal leave and told about his experience. He then started a discussion of criteria for choosing wives and led on to the subject of jobs, schools, and feelings of inferiority, as if to keep himself the center of attention and support his point that his experiences were as valuable as the others' college degrees. He changed the topic when they ceased to keep their attention focused on him.

Two members showed their sense of responsibility for the group. When Dr. P indicated that the meeting was adjourned, Merrick showed his concern for putting on a "good meeting," saying, "I think this has been very good. I wonder if we handled it as it should be?" In his next individual session Merrick said, "How did the group meeting come off? I felt I acted in the role of adviser, not really participating. The silences worried me; sometimes I asked questions simply to fill in the gap. Three times I asked you if the meeting was going as you wanted it to. I was worried about it. I wondered if it was being conducted the way you liked." Kapp, in his next individual session, also showed a feeling of responsibility for his participation in the group: "Nobody's forced to say anything, are they? To tell the truth, I was all keyed up. They were talking about things that pertained to the core, but I couldn't talk up."

Dr. P gave the impression of being interested in the patients and tried to indicate supportiveness by his facial expression but did not succeed in communicating his attitudes toward the patients. He left the responsibility for the conduct of the meeting entirely in the hands of the patients, who were ashamed to bring up in the group the subjects they had previously discussed with the doctor. This combination of the doctor's *laissez faire* attitude and their own fear of revealing themselves may have brought about the competition for status around general qualifications with avoidance of specific problems. It also made two of the patients question whether their conduct in the meeting had satisfied the doctor. Their concern may have been related to the knowledge that they had not been frank and also to their perception of the doctor's need to maintain himself as an intellectually superior person, despite his seemingly broad permissiveness.

### **Dr. K's Group**

Dr. K was one of our less experienced psychiatrists. He had misgivings about the value of group therapy and left it to his patients to de-

cide whether they would join the group. He feared his own need to control and bent over backward to be non-directive. In preparing patients for the group he told them he would function as a "participant observer" and would sit at the table with them but would not lead the discussion. The four patients who attended the first meeting had had from eleven to twenty-six sessions of individual therapy. All had received graduate training for some profession and had shown in Rorschach tests marked drive toward intellectual productivity. All had expressed discouragement to Dr. K because they had not done as much as they expected of themselves, and all showed obsessive-compulsive traits.

Dr. K was reluctant about having the group observed but permitted it. He opened Meeting 1<sup>o</sup> by saying, "I need make no introductory remarks, I've talked to all of you about this. I don't know just what you'll want to talk about." Then he did not speak or show by gesture or facial expression that he was participating for an hour; at this point he made a single comment which changed the course of the meeting. The discussion went from "vocations" to "vocational tests" to "creative writing" to "publishing" to "race prejudice." Each topic came up in relation to one of the patients and the rest told something about themselves in relation to it. The patients were intensely competitive: for example, when Hammond said that he was an accountant, Boyden said that he had studied accounting but that tests showed him more suited for creative work. Turner said his tests showed he had an aptitude for accounting. Hammond damned the tests but added, speaking to Boyden, that his tests indicated creative aptitudes too. Boyden told of unsatisfactory experiences in trying to get poems published. On this topic Hammond said pompously, "Too much is plagiarized from the classics." Turner said that the real trouble was plagiarism "from each other"; then gave his views on modern poetry, using professional jargon. Boyden said that, regardless of theories, as an unsuccessful poet, he knew about publishing. Turner and Hammond continued to try for the last word on what constituted good poetry, but Hammond could do little in the face of Turner's superior knowledge.

Steele criticized the remarks of the others and introduced his idea that there was a message of brotherhood in modern poetry. Hammond, whose bluff was being called by Turner, used this remark to shift the topic to race prejudice. He said he was born and reared in the South and that Southerners were breaking through the crust of race preju-

\*Aspects of this meeting are summarized in Table 8, under Situation Analysis A.

dice. Turner and Steele each tried to show that he had more extensive information on race prejudice, and Hammond became ingratiating instead of pompous. Turner said that there was much to be done about prejudice in the whole country. Steele asserted that his specialty was South Africa, and that he knew race prejudice to be a world-wide problem. Hammond questioned Steele about South Africa. Turner mentioned that he was a specialist on France and made the point that the French had no race prejudice. When Hammond tried to salvage his point that at least the South was less prejudiced against Jews, Steele claimed better information, saying that he too had been reared in the South and brought up to be prejudiced.

At this point Dr. K intervened by calling attention to the time and asking, "I wonder if you have any idea of the trend of the discussion?" The group apparently interpreted this remark as meaning that the doctor expected them to become more personal. Turner suggested that they examine their feelings toward psychoanalysis and a rally followed on this topic and on resistance to therapy, led by Hammond. The tension seemed somewhat relieved, and the discussion became more personal.

Hammond described his anxiety attacks. Turner said he spoke from experience of three years' previous psychotherapeutic treatment for a homosexual problem. Steele: "Now in my own case (stammering). . . . We all have feelings of homosexuality . . . service aggravated. . . . I come in to have it cleared up. . . . The former British Ambassador stammered." To a question from Hammond, Boyden replied that his own self-consciousness stemmed from family difficulties, which he described. Steele remarked that all family difficulties seemed to have an element of incest, held in check by the prevailing culture, and Hammond obligingly tried to show this to be true of his relations with his sister.

In the initial meeting of his group Dr. K was extremely passive. He sat hunched over the table with a fixed, worried expression. The responsibility for the first part of the meeting was left entirely to the patients, the doctor giving them no support or direction. Consequently the only thing left for the patients to do was to try to show themselves to their fellows as they wished to be perceived; they made no effort to get the doctor's attention. Since they were highly intelligent, they competed intellectually for status and therefore could not talk about their personal difficulties. The tension led to a series of attempts to rally around general topics for short periods. These were entirely

different in content from any that the patients had discussed in their private sessions.

After Dr. K intervened, the discussion rallied around resistance to therapy—the topic that was uppermost in the patients' minds. This may have been facilitated by Dr. K's first show of interest, since shortly after his intervention the patients began to talk of problems which they knew from individual sessions were of interest to him.

The four summaries of early meetings given above illustrate the effects of the doctor's being overly directive, active in the wrong way, or not active enough. Situation Analysis 2 describes briefly the first meeting of Dr. N's Group III, the group which got down to work most rapidly. This seemed to be partly because it was the only group composed according to a plan (see Chapter IV), and partly because the doctor, relying on experience with his previous groups, was able to intervene more successfully. He silently permitted the patients to exhibit their defenses until they became clearly dissatisfied with what they were doing. He then intervened decisively by indicating to the group as a whole rather than to any individual the kind of behavior he approved without expressing disapproval of previous activity. The patients responded by bringing out matters of genuine concern with appropriate emotions.

### *Situation Analysis 2*

#### **DR. N'S GROUP III, Meeting 1**

**PRESENT:** Akers, Cann, Minor, and Goodfriend\*

**SETTING:** The doctor had seen these patients individually two or three times but planned not to see them individually after the group meetings started, except as special therapeutic need arose. His goal in Meeting 1 was to wait until a feeling seemed to be shared by several patients before he commented on any individual patient. He also planned to accept intimate or compulsively revealed material, but to postpone discussion of it with such a remark as "Perhaps we'll be better able to discuss this when we know one another a little better."

In Meeting 1 the four members present seemed eager to please the doctor. All but Cann were very rigid. From their previous individual sessions they probably felt that the doctor expected them to talk

\*For the psychodynamics of these patients see Chapter IV. Situation Analysis 2 is summarized in Table 8.



about their personal problems. In individual sessions Akers had been the only one to talk with apparent ease and without revealing anything of which he seemed ashamed. The others had expressed some shame about their families.

After introductory remarks about the confidential nature of material discussed at group meetings, Dr. N responded to questions by Minor about procedure, indicating that he thought they ought to examine their feelings about the present situation, but gave no further instructions. Minor immediately took over, focusing on others rather than himself. First he initiated introductions around the table. After the handshakes there was an uneasy silence. Cann then asked Dr. N directly whether there was any way that the patients could tell whether they were making progress or not. Dr. N did not reply. Then Minor broke the silence to say that he had been to see Dr. N twice and had felt relief from tension; could see a world of difference already. Cann said that he had been having a rather "reverse reaction"—his old trouble, diarrhea, had returned and was giving him a rough time. Dr. N made no comment. Akers then volunteered that he had had only two visits with Dr. N but that these had helped him a lot, enabling him to do his job with more ease. Goodfriend remained silent.

Then Minor, as though noting Akers' easy agreeableness, began questioning him about his reactions on his job. "Did you feel that the boss was watching you and, if you weren't doing something, that your job was jeopardized?" Akers said, "No," but added that he might have felt somewhat that way. Minor: "Now do you think you actually felt that way, or were you just imagining it?" Akers: "Yes, it was just the impression I had myself, within myself." Minor continued with such questions to Akers for about forty minutes, occasionally giving advice and sometimes presenting a superficially parallel experience of his own.

Although Minor's questioning of Akers dominated this part of the meeting, Goodfriend and Cann were drawn in occasionally. After Akers, in answer to Minor's question, said that he was a plumber Goodfriend talked for the first time, saying to Akers that before he went into the service he had worked in a shop too. He was slightly critical of bosses who stood behind you and wanted production. Later, as Akers described a particular problem at work, Goodfriend advised him about how to handle certain jobs and the two launched into a discussion of certain technical aspects of the work. Goodfriend became silent as Minor brought the discussion back to Akers' feelings but later again followed Akers in criticizing bosses.

Cann's occasional questions to Akers were more pointed than Minor's and seemed to indicate a desire to outshine Minor. For example, when Minor probed Akers about his boss's reactions, Cann skillfully asked Akers about his own feelings in regard to the boss's attitude. Later Cann contradicted Minor to support Akers in the latter's opinion that squawking, not ability, got pay raises, and Minor backed down. Throughout the discussion Akers spoke of his feelings, though he did not see his part in producing his difficulties. The others did not talk about their attitudes.

EVENT: Dr. N had not spoken for forty minutes. In the last five minutes the discussion had become quite general and superficial. Akers had stopped talking two or three minutes. Then the doctor observed in an easy, friendly way, "Apparently there is only one person here today who isn't afraid to talk about himself."

EFFECTS: Following this remark, all the patients spoke more or less directly of feeling tense and then all except Akers became quite self-revealing. In the first phase, Minor suddenly sat back, crossed his arms on his chest, was silent and self-absorbed and looked disgusted with himself. (Later, when talking about himself in individual sessions he said, "I didn't like myself very much.") He now repeated the doctor's observation that Akers was the only one who had really talked about his problems today and then added, "Perhaps next time (pause) one of the others might talk about himself."

Goodfriend showed his tension by immediately questioning the others about their "anxiety complexes," then giving his own associations of hearing a whistle in childhood "under pressure," and this reminded him of a nightmare of falling, and his dread of being late. He repeated his concern about being late, specifically to the group meeting.

Akers remarked tensely that he had also been afraid of being late here today. He asked Cann whether he felt tense about having to go back to work and then directly asked how long therapy would take and whether it would do any good. He brought up his difficulties about telling the boss that he had to come to group meetings. He seemed also to be anxious to leave the group. This discussion seemed to make him more uncomfortable than his earlier descriptions of his feelings. Cann expressed feelings similar to those of Goodfriend and Akers about being late, apparently to get the doctor's attention. He then promptly asked the doctor about his increased symptoms and his diarrhea.

Cann started the second phase by talking vaguely about his trouble with his wife. The doctor, following his plan to put off very personal

material until later meetings, tried to postpone consideration of this. Cann asked about time limits in the group, questioned the value of the "chattering" of other patients, and then, refusing to be diverted, talked about his wife and gave a detailed description of his rages. Goodfriend talked superficially about his trouble with his wife and his own "complexes," which he felt he should not be thinking about. Minor became quite red in the face as Cann discussed his rages at his wife, then expressed with concern his resentment toward his own wife, and finally came through with his anxiety about wanting to behave violently toward her, which he relieved by such activities as scrubbing the bathroom floor. After Minor's remark that he wanted to crush things, Cann told about similar feelings and admitted that he sometimes did not want to stop them.

Akers did not get involved in these discussions. The doctor was not defensive about Akers' doubts about psychotherapy and was acceptant of the feelings of the others and the material they brought out.

**DISCUSSION:** Minor typically assumed responsibility for making others do a good job in order to please a higher authority than himself, to the point of arousing their resentment; this had occurred in his family, in the service, and on his job. In the group this took the form of promoting Akers' self-revelation, which was probably useful for the group as a whole as it represented a compromise between what they all probably thought was the doctor's expectancy and what they felt able to do among strangers. Group mores in this first meeting obviously had not developed to the point where patients could be sure of acceptance of really personal material by the group. The doctor's capacity for acceptance and not being shocked had not yet been demonstrated in the group. That the patients went as far as they did may have been due to their experience with his acceptance in individual sessions.

By remaining silent for forty minutes, Dr. N allowed the formation of the comfortable relationship between Minor and Akers; he did not intervene when tension mounted, until he felt that the patients were dissatisfied with what they were doing, as shown by the desultory nature of their talk. His intervention implicitly gave praise to what one patient had done without criticizing any one of the others. It was phrased so that it did not demand a response from any one patient. Minor's activity was not criticized but was shown up by implication. This might have enabled the group to feel responsible, jointly, and in a mutually supportive way, for changing its procedure. The doctor, by indicating that he was aware that all the patients were

involved in the situation, demonstrated his insight into the anxiety that each one was feeling.

The patients, by first talking about their tension in the immediate situation and then about their problems, indicated that they understood the two aspects of the doctor's remark—his acceptance of their feelings and his expectancy that they would talk about themselves. Minor, who apparently took Dr. N's remark most emotionally, had the strongest need to run things as he thought the boss would want them. Akers showed more affect in stating his misgivings about therapy than in his earlier discussion of personal problems which, in retrospect, seemed to have been motivated by a desire to comply rather than by a genuine desire to talk about himself. Cann, who had the least concern about the opinion of his peers and was more directly oriented to the doctor than the others, was the first to reveal a difficult personal problem which was humiliating to him.

**TENTATIVE DEDUCTION:** It appears that, in a group of patients who were eager for help but afraid to reveal themselves among strangers, the doctor was able to help them bring out matters of genuine concern with appropriate feelings by not interfering with their defensive behavior until they were themselves dissatisfied with it. This intervention was successful because of its timing and because the doctor supported the procedure of which he approved, made no mention of disapproval, and implicitly included the whole group.

#### REACTIONS OF PATIENTS DURING EARLY MEETINGS

For descriptive purposes we have divided the patients' reactions during early meetings into (a) reactions to the doctor and (b) reactions to other group members, although of course recognizing that each patient's reactions were determined to some extent by those of the doctor and those of his fellow patients. The personal characteristics of the individuals involved are of course implicit in any discussion of attitudes; in the present study, for example, while competitiveness between patients was usually promoted by certain attitudes on the part of the doctor, some patients remained passive.

##### *Reactions to the Doctor*

In early meetings the patients regularly regarded the doctor as the only source of help and guidance. This led them to try to get him



to solve their personal problems or tell them what to do in the group situation, or to try to comply with what they thought he wanted. They also tended to vie with one another for the doctor's interest and attention. The early relationships with the doctor were thus charged with tension and conflict, arising from several sources. The doctor could not solve their problems and would not give them explicit instructions as to procedure. Their own needs conflicted with their attempts to comply with what they thought he expected. Rivalry for the doctor's interest added to the tension. Some illustrations of these phenomena and of how the patients dealt with their tensions can be found in the preceding section. Others follow.

*Tension resulting from fruitless attempts to find out what the doctor expected.* An example from Meeting 2 of Dr. N's Group III illustrates how a patient who experienced considerable anxiety over his dependency, which he covered by aggressively assuming responsibility and leadership, was helped to recognize the relation between his anxiety and situations in which he was left without direction by the doctor's refusal to guide him.\*

Bridges, who was present for the first time, argued against the other patients' contention, that fishing and other forms of relaxation might help solve one's problems. After he had hotly and uncompromisingly presented his point of view, Bridges asked whether members of the group ought to begin with definite problems. The doctor did not answer, because he wanted Bridges to become aware of his anxiety in an undefined situation. Turning to Dr. N, Bridges asked, "Are we supposed to get to the point we want to clear up? (silence) Do you think we ought to know a little about each case? I don't know these gentlemen. Maybe it's none of my business. . . . Do you think it is? I feel that we should have something in common." When Dr. N remarked that Bridges was taking responsibility for trying to get the doctor to give directions, Bridges replied, "I just wondered what you wanted us to do." In his interview with the social worker after several group meetings, Bridges expressed a good deal of distress about the lack of definiteness in the procedure and spoke about becoming anxious when he feels uncertain, not only in this, but in many other situations.

*Conflicts over attempts to comply with what patients thought the*

\*See also Situation Analysis 29.

*doctor wanted.* Patients sometimes tried to comply with what they believed to be the doctor's wishes by putting on a good group meeting for him.\* In such cases they usually attempted to comply with the doctor's wishes by bringing up personal problems. This was relatively easy to do if the problems did not involve the patient's self-esteem—for example, telling about his symptoms or service experiences. However, if the problems were more threatening, compromises appeared—as when one patient started to question and advise another about his problems, apparently as a way of reconciling his own conflict between fearing to reveal his weaknesses and wanting to do what the doctor expected.† Similarly, if the doctor asked a patient what was on his mind, he might talk about the problems of someone close to him, such as a girl friend. A common dodge of patients if pressed by questions was to recite their symptoms.\*\*

In general the conflict between attempting to please the doctor and reluctance to reveal threatening personal material was manifested by a tendency on the part of group members to discuss generalities, superficialities, and complaints and then, on pulling themselves up or being pulled up by the doctor, to touch on more personal matters, only to wander off again to safer grounds.

Difficulty sometimes arose when a compliant patient went too deeply into his problems before he felt assured of understanding and acceptance from the doctor and the group. Or when, in an effort to get help, one member of the group blurted out intimate or disturbing material and others fostered this self-revelation as a way of keeping attention away from themselves or from more sadistic motives. The result might be to increase the patient's anxiety to the point where he left the group or even gave up therapy entirely. In one such case, when Conner had poured out his resentful feelings about officers and military life in response to the doctor's suggestion of service experiences as a topic, the rest of the group attacked his attitude—perhaps because the doctor, a former officer, seemed uneasy.††

\*This was clearly expressed by Merrick in the account given above of Meeting 1 of Dr. P's Group I. It also played a part in Minor's questioning of Akers in Situation Analysis 2.

†Cf. Minor in Situation Analysis 2.

\*\*See account of Meeting 2 of Dr. L's Group, pp. 119 f.

††See Table 10 under Situation Analysis c.

It should be added that in our experience no patient was driven out of a group by the revelations of another, no matter how "shocking." Apparently, neurotics share with the rest of humanity the ability to defend themselves against material which would be too disturbing if they permitted themselves to perceive its full import.

*Tension alleviated by expressions of confidence in treatment.* Another frequent phenomenon in these early meetings was the interplay between more or less open hostility to the doctor and reports of progress or expressions of confidence in him. The latter seemed to be a device that patients used to placate the doctor or to reassure themselves after having expressed doubts about therapy.

The testimonials with the least hostility occurred in Dr. X's Group, possibly because the patients attempted not so much to placate as to comply with the doctor's desire for reports of progress.\* In the first meeting of Dr. N's Group III Minor and Akers offered testimonials to therapy apparently as a reaction to their annoyance at the doctor for not telling them what to do, as if to reassure themselves that there might be something in his approach after all. Cann, however, pointed out that he was worse. Later in the session Akers expressed indirectly his doubts of the value of psychotherapy.† Even the openly hostile patients in Dr. L's Group fell back on progress reports. This may have been because of a need to restore their faith in therapy which was endangered by their hostility in this very early phase.\*\*

### *Reactions of Patients to One Another*

Each patient tended to see the others partly in terms of how they might affect his relationship to the doctor. Attempts to assert superior knowledge, to be helpful, and to have similar or worse complaints were all motivated to some degree by the need to stake out claims to the doctor and to make sure that he perceived the patient as an individual.

*Rivalry for the doctor's attention.* The following excerpt from an account of a group meeting run by a substitute doctor illustrates how

\*See account of Meeting 2 of Dr. X's Group, pp. 116 ff.

†See Situation Analysis 2.

\*\*See Charles's attitude in the account of Meetings 1 and 2 of Dr. L's Group, pp. 119 f.

the relationship between two patients was chiefly determined by their rivalry for the regular doctor—each vying with the other in his attempt to appear more in need of help, in praising the absent doctor, and in displaying his knowledge of psychiatry. This was not merely a function of the personalities and techniques of the two psychiatrists involved, for it occurred when other doctors substituted for each other.\* The example also illustrates how the presence of a substitute doctor might aid a patient in expressing his misgivings about the regular doctor and in showing aspects of himself which he had been unable to reveal to the latter.

Dr. N substituted for Dr. P in Meeting 15 of Dr. P's Group 1. Five patients attended, but Stern and Merrick played the major roles. This was the first group meeting that Stern had attended, although he had had previous individual sessions with Dr. P. In his first individual session he had sought sympathy by telling of the neglect he had suffered as a child and at other times. It will be seen that he reverted to sympathy-seeking in the following situation. Merrick had attended the fourteen previous meetings of this group and had also had individual sessions with Dr. P. He behaved in this meeting as he did in the others.

Almost immediately after the meeting opened Stern asked for an aspirin. At the doctor's request, the observer left the room to get it. Merrick told Dr. N about his masturbation, which he had described at the previous meeting. Stern interrupted, "I hadn't told Dr. P about this, but I've got the same problem. I've always been ashamed to bring it up before him. When I get bills, I get shaky. . . . I have intercourse every night when I'm upset, and I also masturbate a lot. . . . I never thought I'd bring up this sort of thing in a group." As if to show he was a better patient, Merrick replied, "I'd bring up anything here I'd bring up with the other doctor," and then continued to talk about his masturbation. When Dr. N started to question Merrick about this, Stern interrupted to say that the doctor's question reminded him of a problem that Dr. P had cleared up for him when Stern was cheating on his wife with a woman who looked like his mother. Merrick then proceeded to talk very rapidly about a variety of problems. When Dr. N made a comment indicating agreement with an interpretation Dr. P had offered to Merrick, Stern told how Dr. P's help in clearing up a problem had eased his need to masturbate, then recommended that Merrick ask Dr. P for amytal. After a brief digres-

\*See Chapter XIII.



sion by another patient, Merrick told about how Dr. P removed mental blocks. Stern agreed that Dr. P was good, then started to talk about his battle dreams. Merrick tried to interrupt, saying, "I have the craziest dreams," but Stern overrode him and continued to explain how his battle dreams were the key to his difficulties. He then advised Merrick to ask the doctor for the "truth dope," adding, "I've been reading books on psychiatry." Merrick said he had too.

*Competing for superiority.* Competitiveness appeared very early and was quite prevalent in our groups. Its purposes seemed to include both impressing the other members and indicating one's "worthiness" to the doctor. As already pointed out, it was apt to be particularly intense when the doctor was so passive that he did not communicate to the patients what his attitude was or what he wanted them to do. The more passive the psychiatrist, the more rampant the competition was likely to be.\* Sometimes it revolved around superior knowledge, especially about psychotherapy, as in the example just given; patients who could not compete in the realm of book-learning often claimed greater life experience, being more a "man of the world," as the basis for superiority.† Competitiveness also appeared in the guise of asserting differences from and similarities to others.

*Advice-giving.* Interest in the problems of another patient, often accompanied by advice-giving, occurred early in almost every group. But one patient's apparent attempts to be helpful to another were not necessarily expressions of benevolence. It was possible to distinguish at least three other motivations. One was an attempt to keep attention away from the patient's own problems by evincing deep interest in those of another. A second was to assert superiority to the doctor as well as to the other patients. In such cases the patient might be trying to show the doctor what he should be doing. This is illustrated by the following two examples, one of which comes from a fairly late meeting, the other from a social work interview. In both cases the attitude was presumably present from the early meetings, but the patients had not verbalized it.

Rothschild, a patient in Dr. K's Group, often appeared to be trying to help the doctor. In Meeting 26, after describing a feeling of need-

\*See account of Meeting 1 of Dr. K's Group, pp. 123 f.

†See account of Meeting 1 of Dr. P's Group 1, pp. 121 f.

ing to protect the doctor, he said that he wanted to be restrained when he looked out of the window. Dr. K: "You're also up high. I'm in a high position, superior; do you want to tear me down?" Rothschild: "Yes, when Hammond spoke I wanted you to get out of the room, so that I could help him and question him better. Your ability to judge bothers me."

Rosen, a patient in Dr. Z's Group, had appeared to be solicitous of other patients in the group, asking questions and giving advice and interpretations. He made frequent use of psychiatric jargon. In an interview with the patient in which his reactions to the group were discussed, he remarked that he felt that some of the other patients talked easily because Dr. Z was present and they wanted to make a good showing. He added that he might have said "put on a good show." The patient then said he felt a conflict with some of the others in reference to Dr. Z. He would have liked to appear as the most important and intelligent patient present—the keenest analyst and the finest patient in the group—to prove that "these other fellows are just a bunch of sticks."

The third motivation—apparent helpfulness and consideration—might also conceal contempt, as in the following example, in which one patient's apparent consideration of another proved to represent a transference reaction.

Coombs had been introduced to Dr. N's Group in four meetings previously. From his first meeting he had been kindly and patronizing toward Ingram, a timid 23-year-old schizoid patient who looked and acted younger than his years. Coombs had questioned Ingram about his problems very politely and on one occasion had angrily attacked another patient when the latter was hostile to Ingram. However, in the preceding meeting Coombs had said that he thought Ingram was the doctor's favorite and that when the doctor talked to Ingram it was like watching "a little nursery." In the meeting under discussion Ingram was in focus for a long time and described many of his attitudes and actions as deceitful. When he finished, Ingram said that he wondered what Coombs would think of him and that he didn't want any hard feelings between them; he added that he was scared about the remark Coombs had made about the little nursery. Under questioning from the doctor Ingram insisted, "I don't want what I say to bother him," but he blocked when Coombs questioned him. At that point the doctor said that he had had the feeling that Coombs was patronizing Ingram, and another patient added that he thought

Coombs had been patronizing them all. Ingram said that he felt badly because they were scrapping over something he had said. Coombs explained that he was sympathetic with Ingram because the latter was young and boyish; he wondered why he couldn't have had this treatment at Ingram's age. The doctor reminded Coombs of his younger brother, to whom he was always overtly sympathetic and kind but whom he hated because the brother was the mother's favorite. Like Ingram, this brother was dominated by his mother.

Later the doctor noted that Coombs had been waiting for Ingram after meetings and asked Coombs if he were feeling friendly toward Ingram. Coombs said that his feeling toward Ingram was protective but that he had to watch it lest it become condescending, thus clearly indicating that he knew that his kindness concealed some contempt. Ingram also must have sensed this, because he frequently remarked that he wondered what Coombs really thought of him. Like many schizoid people he was acutely aware of the hostile components in the attitudes of others.

*Reporting similar complaints.* Patients often responded to the complaints of others by describing similar ones. This might represent an effort to establish rapport or to get the focus of attention by linking to what another man had said and then going on with one's own concern. Or it might represent an attempt to assert his greater need for attention by discussing the other man's complaint in a belittling way as if to say, "I don't complain about little things like that. I have a *real* problem." The use of similar complaints as a way of expressing feelings of superiority is clearly shown in the following example, which also illustrates pseudo-helpfulness as a way of competing with the doctor.

Dr. P started his Group II off by reminding the patients that they were there for a serious purpose and asking for problems. Three of the four patients who were present responded with brief summaries of their difficulties, being careful to preserve an appearance of dignity. The fourth, Crosby, a schizophrenic in remission, made a sympathetic comment after each of the others had finished.

When Happ's turn came, he talked frankly about not being able to get an erection. Next, he described a startle reaction when planes flew over. Then, lamenting his uncontrollable anger, he told about a nagging mistress whom he had "hit a few times." Crosby, appearing helpful, tried to show that he could accept and had mastered all the

problems the others could present, and that they really had nothing to complain about: "Maybe she needed it. . . . There have been times, too, when mine wouldn't get hard. I thought that would be the case when I got married, but it definitely was not." (Happ squirmed uneasily as Crosby spoke.)

When Dr. P tried to get another patient to tell why he had given up his chair to the doctor as the meeting opened, Crosby revealed that he was really concerned with dominating the group. "If I were running the group, I'd sit where I could see all and control the group." Gorley interrupted, "Any of you fellows disgusted with yourselves?" Crosby, "Why sure, I thought myself guilty of the most heinous crimes." Gorley insisted that his service career had been a failure. Crosby: "You have been through hell. What difference does it make?" Happ replied, with an oath, that he didn't seem to be able to get going in civilian life and added that he had never cursed before he was in the service. Crosby: "Fellows in the service curse all the time." Happ: "I want to get away from it, you're taking God's name in vain." Crosby: "How do you know?" Dr. P: "Mr. Crosby, what's your purpose in doing this? What has it to do with you?" Crosby: "I wanted to show that the Commandments are obscure and that I may not be taking God's name in vain, but that's your job, isn't it?"

Further futile efforts in the next six meetings to prevent Crosby from upsetting the group by representing himself as both the sickest and the healthiest patient, while he became increasingly grandiose, led the other patients to conclude that he had no problems to discuss. He left therapy for several months.

*Clowning.* Another pattern which appears early is clowning—trying to amuse the others at one's own expense. Insofar as we have understood this behavior, which is usually habitual in social situations for the men who show it in the group, its main purpose seems to be to relieve one's own tension by breaking the tension in others and getting their amused attention. There is usually, however, an undercurrent of contempt for oneself and the others and, in the attitude of hopelessness about psychotherapy, a subtle derogation of the doctor. Sometimes clowning may be part of a masochistic pattern, as in the case of Alban, who repeatedly incurred the amused contempt of the group. This patient was used to being ridiculed by his younger sister and mother and had a deep feeling of hopelessness about himself. Street, who was older than his fellow patients, associated to



others' difficulties by telling of an inadequacy in himself, in such a way as to bring laughter. He told how he felt "kicked in the face" when his efforts to be "one of the boys" were unsuccessful.

Aggerston, who habitually told about his problems in an exaggerated way that was often uproariously funny, used clowning as a way of dominating the group. He was a man who basically distrusted everyone but who presented a front of being the life of the party, which had enabled him to dominate social gatherings. For example, he talked repeatedly and emotionally of his contempt and distrust of certain of his relatives who took advantage of his mother. In the seventh meeting of his group he found himself a minority of one in advocating racial discrimination, although he was very circumspect about it. However, this was apparently a traumatic experience. In the eighth meeting he remained silent (very unusual behavior for him), but when others talked of embarrassing incidents in their past, Aggerston responded with an entertaining account of some embarrassing moments of his own. He described his severe temper tantrums as if to top another patient's account of blind anger in a certain situation. He added that he was sure the same thing would happen again, that nothing could be done about it, although he knew how foolish it was. His behavior impressed the doctor as representing, simultaneously, an attempt to dominate the others, by getting back into their good graces after having opposed them on the discrimination issue, and an expression of contempt for them and for himself.

*Silence.* Many patients responded to the tension in early meetings by participating as little as possible. They sat silently and answered as briefly as possible if addressed. This rarely indicated a strong resistance to therapy; it might simply be due to shyness which blocked active participation in spite of a desire to take part. Such patients usually gave autonomic indications that they were by no means indifferent. Nearly always they talked eventually and then were found to have been much influenced by what they had heard.\* The point to be made here is that the patient who is silent in the first few meetings usually need not be a cause for concern.

\*Ways in which such patients are brought from silence to open participation are described in Chapter XI.

## SUMMARY AND IMPLICATIONS FOR THERAPY

Patients may experience frustration and conflicts during the early meetings of the group, but the unclarity of the situation is useful therapeutically because it mobilizes characteristic patterns of behavior. Each patient's perception of the situation depends partly on its objective qualities—the actions and attitudes of the doctor and the other patients—and partly on his habitual ways of seeing any new social situation.

It would seem that the doctor's aim in the initial stages of group therapy should be to sense when and how to give the amount of direction and support that each situation demands. Too little guidance often results in intense competition for superiority, which only upsets the patients without leading to anything beneficial. Too much guidance, on the other hand, may inhibit the appearance of the neurotic patterns, the analysis of which is part of the objective of psychotherapy. Instead, the patients tend to produce what the doctor requests, whether it is really important to them or not, and to relate to the doctor and to one another in the framework set by him.

The specific goals and activities of the doctor should grow out of his perception of the particular situation. We have no set rules as to when the doctor should encourage the patient to discuss personal problems or what his attitude should be toward the group. There are, however, certain cautions to be observed. For example, the doctor should guard against the tendency of some patients to rush into revelation of painful material before the group is ready to support them. If his burst of self-revelation meets with no response, a patient may feel chagrined and embarrassed and may leave treatment. Conversely, if the doctor is too eager to examine the patients' attitudes toward one another before they have had a chance to make themselves relatively comfortable by utilizing their usual defenses, he will drive certain patients from the group, especially the rigid ones who cannot relate at this stage except through their habitual mechanisms. The doctor should also keep in mind that the examination of attitudes is a new and strange procedure to most people and that they need time to get used to it. If the doctor thinks of himself as a participant

observer in the group, it heightens his awareness of when and how to intervene. It should be stressed, however, that this phrase implies participating as well as observing. He participates by making his observations at the proper moment. His intervention should indicate to the group how he expects therapy to proceed—particularly the propriety and usefulness of the patient's free expression of his intimate feelings and thoughts, whether experienced in relation to the group or to his outside life.

## CHAPTER VI

### *Group Functioning in Later Stages*

---

As a therapeutic group continues to meet, certain changes in patients' behavior may be expected to occur and long-term patterns relevant to the therapeutic process begin to appear. The first section of this chapter briefly discusses some of the differences between early and late group meetings. The second traces out the development of certain themes in a mature group and illustrates how patients' discussion of these is related to change in the level of tension.

#### SOME DIFFERENCES BETWEEN EARLY AND LATE MEETINGS

In trying to determine how newly formed and mature groups differ, it proved important to try to distinguish between those changes in patients' behavior which indicated that they had learned to work psychotherapeutically and those which indicated clinical improvement. Functioning in the group may mirror a patient's improvement, in that he may show a more realistic appraisal of the doctor and the other patients, a greater awareness of his own responsibility for modifying his relationships, and so on. However, a patient may be on the way to improvement and yet at the time of observation show gross distortions in his perceptions of others, childish appeals for sympathy, a sharp increase of symptoms, bouts of self-indulgence, and other signs that make him appear sicker than he was at the start of treatment. In other words, he may be in the throes of working out an acute transference reaction or in a state of regression due to the breaking down of defenses, which is usually part of the process of becoming emotionally aware of a hitherto hidden problem.



Regardless of their clinical state, however, patients in experienced groups tend to show differences in behavior from those in newly formed ones. Such differences are connected with their increased grasp of the principles and methods of psychotherapy and with the development of the group itself as a therapeutic agent. These behavioral changes may occur without clinical improvement, but it is doubtful whether significant improvement can occur in their absence.

As pointed out in the account of the early meetings, at first patients seemed confused about what they were supposed to do; they were in conflict between their desire to act in a way which the doctor advocated as psychotherapeutic (i.e., discuss personal problems) and their need to protect their self-respect and diminish their anxiety by means of conventional social amenities. Those who remained in the group may be presumed to have resolved their conflict in favor of the efficacy of psychotherapy. That is, they were usually convinced that their symptoms were rooted in interpersonal difficulties rather than organic defects and that the road to relief lay in exploring their feelings and attitudes. They had become resigned to the fact that psychotherapy took time and could not be rushed. Through practice they had become increasingly able to analyze their feelings and reactions to others and to grasp more complex interrelationships. As experience in working together accumulated and patients learned more about one another's personalities and problems, the group itself became a therapeutic agent. Each patient felt himself treated by the doctor and the group rather than by the doctor in spite of the group. A group code and set of values developed, so that more prestige came to be attached, for example, to trying to work through one's problems or express one's feelings honestly and less to appearing competent or being entertaining, and this influenced patients' behavior. Patients came to feel that their real selves would be accepted and understood, and so they became less concerned with impressing one another, protecting themselves, or demonstrating claims to special attention. They came to realize that since they had problems in common it paid both to speak about their own and listen to those of others.

Comparison of Meetings 1 and 65 of Dr. N's Group n\* shows that

\*See Appendix A.

in Meeting 1 discussion consisted largely of short comments by patients speaking in turn and rather hastily. In Meeting 65 there were a few rather long monologues which were listened to with obvious attention. A single theme—hostility toward the doctor—occupied most of the meeting. The patients were better able to empathize with one another and to participate in common moods, so that association to one another's material became easier and more profitable. They had become better able to tolerate tension, knowing that nothing disastrous would happen even if considerable emotion was shown—that tensions would eventually be resolved. Increasing familiarity with the method of therapy and increasing feeling of support from the group were reflected in Meeting 65, particularly in respect to assuming responsibility for one's attitudes toward other people and improved ability to analyze such attitudes.

In Meeting 1 of Dr. N's Group  $\pi$  the patients had little conviction that they were at least partly responsible for their distress and that relief could be obtained through expression and analysis of feelings. For example, when the doctor asked Mason for specific examples of his difficulties, the patient talked at great length of how high-strung his wife was, of his son's asthma, and of arguments with the neighbors, but was unable to say anything about how he affected his wife and family—he thought that his problem lay in externals beyond his control. Pim said that he couldn't show his own emotions and was bothered by people who did. He attributed his irritation to "years of home training on the thing to do." When Dr. N asked why, in that case, the patient should become angry at those who do show their emotions, Pim replied that he didn't know and would like the answer. He then remarked that he considered such behavior a "breach of good breeding," and Ingram agreed that some people did not appreciate good manners. Ingram and Pim were judging others with little or no awareness of the reasons for their own negative reactions. Despite the fact that Bly had repeatedly used his knowledge about psychotherapeutic procedures to impress the others, when he came to discuss his own problems, he said that his basic fear was worry about his physical condition and that the doctor who attempted to treat him for this was incompetent.

In Meeting 65, by comparison, interpersonal difficulties were seen as a problem to be examined and analyzed, with some sense of responsibility for these difficulties. For example, Bly said, "I think I

can recognize my weakness, but I don't want to feel I deliberately brought this on myself. Like in the service, if they agreed it was an illness, then I would have self-respect. Otherwise, I deliberately went through all that stuff just to get out of the service." When Dr. N implicitly asked who were meant by "they," Bly explained that "they" were the entire public and then narrowed this down to his understanding that "they" were also his family. Similarly, Ingram said, "When we have something wrong with us in here, we cry for you—yet, when we take a step forward, it's hands off."

Changes between Meetings 1 and 65 were particularly apparent in the patients' attitudes and behavior toward Dr. N. In the first meeting they saw him as the stereotype of the physician who would cure them by giving them advice and telling them what to do. Pim, Hare, and Mason repeatedly asked for direction and guidance and tried to act in accordance with what they thought he expected of them. Doubts about Dr. N were expressed only indirectly and by just one patient, Teaney, who promptly took them back. By Meeting 65 the patients' attitudes to Dr. N were largely determined by transference reactions. Because of their greater tolerance of tension and the diminution in their attempts to impress one another, they were able to express and, to some extent, to analyze these attitudes. Veal, who had participated previously only with bland advice-giving designed to show his own superiority, for the first time criticized Dr. N and was able to elaborate his attitude a little. Ingram could agree that he thought Dr. N was trying to put something over on him. Later he said: "I'm inclined to put you on a pedestal." In Meeting 65 Bly was able to attack Dr. N openly, whereas in Meeting 1 he could only attack other doctors.

Thus, by Meeting 65, the tentative, uncertain atmosphere in which patients seemed chiefly concerned with protecting themselves and finding out what they were supposed to do had been replaced by one of considerable emotional tension, with free give and take and attempts not only to express but to examine attitudes and feelings and to assume responsibility for them.

#### CHANGES IN TENSION IN RELATION TO THEMES\*

The study of themes and their relation to changes in tension may prove to be a productive way of analyzing the processes of individual as well as group therapy. As applied to group therapy, the theme involves

\*Major contributor: Edith Varon.

a number of topics as well as attitudes and feelings, through which patients relate to one another.<sup>1</sup> In the later stages of therapy, despite the number of patients present and the multiplicity of their problems, one or more related themes tend to persist over a number of meetings and to be developed at successively deeper levels in a spiraling fashion. Several members contribute to the discussion, some more tangentially than others, and from somewhat different points of view. Some patients tend to broach certain themes early, while others are not able to join in until much later. We cannot yet say whether there is any regularity in the order in which themes appear in therapeutic groups. As themes unfold tension rises and falls. During periods of rising tension, patients are very irritable and critical of one another and the doctor, as they struggle with a problem. In the cycles cited below, patients were primarily attempting to blame their troubles on others, but as the tension passed its peak, they realized that the source of their difficulty was their own sense of unworthiness. When this painful insight had been achieved by some patients, the group suddenly relaxed and felt exhilarated. In subsequent meetings carping gave way to a mutually supportive attitude. Patients encouraged one another by kindly questioning and offering parallel experiences. They tended to take turns at talking for extensive periods. Sometimes the patients who were not discussing problems seemed so relaxed that the patient who was talking appeared to be having an individual interview with the doctor in the group setting, rather than participating in group therapy. This was not actually so, since the problem this patient was discussing was related to the general theme of the group; it was likely to be a continuing examination of the problem under discussion before the period of tension, but now including the insight which had been achieved.

Examples from Dr. N's Group 1, Meetings 61-79 (two cycles of rising and falling tension) are cited on pages 147-160. At the time of these meetings the group was stabilized in the sense that it had passed the period when patients dropped out; the members at these meetings continued to attend until the group disbanded. They recollected vividly what others had said many meetings before and had gained considerable understanding of one another. Dr. N was permissive and



rather non-directive, allowing patients to relate freely with one another. If a patient presented a problem, the doctor would examine it with the patient and would welcome other patients' participation, becoming silent if their discussion went along well. He examined what was going on in the group chiefly when the therapeutic process appeared blocked. This was usually accompanied by excessively high or low tension. Examination of what was going on in this group occurred perhaps once in three or more meetings. More typically the doctor intervened to help individual patients achieve insight. If a patient indicated that he had gone as far as he cared to for the time being, the doctor would often break the ensuing silence by shifting the focus to another patient rather than wait for the group to do it.

Although members received individual therapy approximately once a week, this did not seem to change the general tenor of the meetings. The meetings had an internal logic of their own to which the experiences of private sessions and real life were assimilated. The following analysis presents the discussions in skeletal form in order to bring out connections which were not immediately obvious to the doctor or observer.

#### PERTINENT CHARACTERISTICS OF GROUP MEMBERS

Dr. N's Group 1 consisted at this time of five patients who differed in their individual dynamics but had much in common in their problems. Hostile relationships among them were more apparent than friendly ones, but there were brief periods when hostility was in abeyance, tension was low, and positive feelings emerged.

Coombs was deeply emotional but had not clearly related his feelings to particular experiences or motivations. He showed remarkable insight into others and used this at times very hostilely and at others supportively. He had strong feelings of inferiority, which would be touched off by Trippitt's behavior, and then he would attack Trippitt unmercifully. He was talented and well educated but had not been able to work for about a year.

Eubank was the most retiring member. In Coombs' phrase he was "a coffeepot about to boil over." He was afraid of what his anger might lead him to do. He had talked somewhat about his difficulties

on the job, and once he had gone into his guilt toward the group which was somehow related to his not talking and to his fear of talking in public as a child. He related primarily to the doctor but once attacked Coombs for seeing violence everywhere.

Milton was afraid to recognize his own feelings. His tolerance for hostility was extremely low and he tended to try to mediate between others who were hostile, but he succeeded in expressing hostility directly to the doctor, describing him as "dictatorial." His attitude toward other patients was defensive; when they suggested an interpretation to him, he would say, "It doesn't present itself to me that way." He had begun to try to apply to himself what others were discussing.

Gugis was originally considered by the doctor to be in danger of a schizophrenic break because of his tendencies to withdrawal and his excessive daydreaming. He would become platonically involved with girls and imagine that he had to marry them, although this was neither necessary nor desirable. At times he would remain silent in the group for weeks and at others he seemed unable to stop talking. He spoke very lucidly and not without affect. He periodically became very despondent and talked of committing suicide as the only way out.

Trippitt was "the good boy," always trying to provide a topic for discussion. He was very intellectual and acted as though he had no emotional problems until he became the target of an attack, to which he responded by beginning to talk about his fear of homosexuality and his inability to accept affection because of his feeling that he lived "behind a front" and that people were responding to it rather than to himself. When insecure he acted arrogant and superior to the extent of saying that he could discern the problems of others better than the doctor could. He was going with a neurotic girl who reminded him of his mother, and he wondered whether he should continue this relationship.

## THE FIRST CYCLE: MEETINGS 61-70

### *Introduction of Themes: Meetings 61-64*

Participation was spontaneous and patients presented their problems as peculiar to themselves. Their discussions, however, were related to the following themes during Meetings 61-64. Patients expressed the last two themes in their feelings toward one another and the doctor as well as in personal material:

*Ambivalent feelings about loving women.* Trippitt introduced this subject in Meeting 61, when Dr. N called for problems that had been brought up in individual sessions. Trippitt talked of his revulsion from sex and his feeling of inadequacy with women. In Meeting 64 Trippitt complained that he needed to love his girl in order to prove that he was healthy but was unable to do so. Moreover, he felt that love was a millstone because of the obligations it entailed. Gugis also talked of sex in Meeting 61; he thought there was something rotten about the fact that sex exists. He distrusted women in general, thought they were insincere. He continued this theme at great length in Meeting 62, protesting that he was shocked by the immorality he saw everywhere and at the same time complaining that girls would not submit to him. In Meeting 64 he agreed vehemently with Trippitt that love was a millstone and that he, like Trippitt, could not tell whether he was in love.

Coombs joined the discussion of sex in Meeting 61 to say he felt like a male prostitute. In following meetings he did not talk about women.

Milton and Eubank questioned others but did not talk about themselves in relation to women.

*Hostility, distrust, and fear of people.* Gugis, in the above-mentioned discussion, intimated his hostility toward women and his distrust of them. In Meeting 62 he admitted that he behaved deceitfully toward them. In Meeting 64 he said that he thought that hostility was the only genuine emotion he had for men as well as women.

Coombs said that he had less desire to beat women up. He took up practically the whole of Meeting 63 with his hostility toward men and women then discovered the fear that was behind the hostility.

Milton briefly echoed Coombs in Meeting 64; he too feared people. Trippitt and Eubank did not speak directly on this topic.

*Feelings of inferiority and desire to be average.* Trippitt talked of his sexual inferiority in Meeting 61; in Meeting 64 he gave his inability to love as one indication of inferiority.

Gugis spoke explicitly in Meeting 62 of his feeling of worthlessness, which he attributed to belonging to a worthless tribe. Inferiority was implied in his problems with women.

Milton expressed fear of flunking at school and discouragement with therapy in Meeting 63.

All three talked of their desire to be average (apparently an alleviation of feelings of inferiority as well as of uniqueness) in Meeting 64.

Coombs and Eubank were not involved in this theme.

*Development of Themes: Meetings 61-70*

During Meetings 61-64 there was a mild increase in tension among the group members. A sharp rise and a slight decline occurred in Meeting 65, and a further decline followed in Meeting 66, but both sessions were predominantly tense. There was an unusual amount of interaction among patients and a relatively small amount of consecutive time devoted to any one patient's personal problem. Tension was manifested through the type of problem presented as well as through the bristling way in which patients participated. It was relieved after members had got rid of some of their hostility toward one another and had achieved new and deeper insights into their personal problems. Meetings 67 to 70 were relaxed. Newly acquired insights became related to the predominant themes, and the friendly member-to-member relationships were not examined.

*Meetings 61-64.* Feelings were most positive in Meeting 61, when Coombs and Trippitt made their peace after a recent feud, each explaining the meaning of his behavior. At the end of this meeting Trippitt said to Dr. N, "You are my old man, telling me about the world." During the discussions of sex the participants shared experiences in a comfortable, non-critical way until Meeting 65. In Meeting 62 Coombs asked sympathetically whether the immorality Gugis referred to seemed to him "the whole of life." In Meeting 64 Gugis was strongly supportive of Milton's desire to be average. These examples illustrate a positive mood, but hostility between members and negative feelings toward the doctor also appeared during this period. Patients gave one another an increasing number of interpretations in an unfriendly way, such as Coombs' expression of anger at Trippitt's authoritativeness in Meeting 63 and his remark in Meeting 64—"I think Gugis is sincere only when he is angry." Eubank intervened rather sharply several times in Meeting 64, as when he said that Trippitt would really be happy if his girl walked out on him because of his fear of the relationship. Negative feelings toward Dr. N were prominent in Meeting 64, in which Milton, Gugis, and Trippitt all expressed considerable dissatisfaction with therapy.

*Meeting 65* fell into three general parts: (1) expression of negative attitudes toward Dr. N, implying rejection of him, (2) expression of member-to-member attitudes, which combined implied rejection with the desire to be taken seriously and the fear of being rejected, and (3) return to work on problems, culminating in the discovery



that the fear of being unloved arose out of the feeling of being unworthy of love.

As described in Situation Analysis 14, negative feelings toward the doctor were obliquely expressed, first by Milton's objection to the Mental Hygiene Clinic sign, then by Trippitt's reference to the sudden death of a former member of the group. The awkward, tense silence which followed Dr. N's termination of the discussion of this topic was finally resolved by a discussion of how the patients reacted to the silence, in which they displayed their rejection of others and their fear of being rejected. Gugis and Trippitt were the chief participants, the former attacking the latter for hinting at a problem, then falling silent. Tension subsequently dropped steadily, and the discussion ended when Gugis said that anyone with Eubank's attitude—of laughing, the more serious the matter was—could never get angry. This was so obviously in contrast to his appearance of suppressed anger that it aroused laughter.

Discussion of personal conflict was then resumed in a setting of friendly helpfulness. Trippitt resumed a topic he had brought up earlier, his inability to love his girl, which he felt was tied up with lack of respect for himself. After a silence he said, "You're right, Gugis, I make a gambit, then go home." Instead of continuing his attack on Trippitt, Gugis supported him with a reminder of a former group member whose feelings had also gone up and down with those of his girl. For the balance of the meeting Gugis and Trippitt together examined the problem of loving—Gugis wondering how you knew you were in love and how you could find a woman you could trust. Trippitt and Gugis began to discover that their attitudes were the same, and tension dropped as they laughed about this. Gugis talked of his feeling of worthlessness—a feeling related to being "the son of my parents"—and Trippitt expressed doubts about himself and his ability to hold a woman. Gugis concluded that he was sure his relatives did not like him, although some of them had named a baby after him. Trippitt asked Gugis how he knew they didn't like him. Gugis said that he "gave them no incentive." Trippitt asked why Gugis had to give an incentive to them. Gugis: "That sounds like Trippitt's problem." Trippitt: "It is!" Gugis: "Mine too!" General laughter.

After having acted out hostility and fear of rejection, both patients were able to progress to the painful insight that they felt unloved because they regarded themselves as unlovable. The fact that the problem was common to both may have facilitated their joint exploration of it. As they reached the insight simultaneously, each felt less unique and the insight was therefore presumably less painful.

The laughter and relaxation of the other patients indicated their participation in this interchange. The insight into the relation between feeling unloved and being worthless was a fusion of two themes which had appeared in earlier meetings.

*Meeting 66* tied up loose ends left over from *Meeting 65* and continued with the development of the themes. It had three aspects: (1) Trippitt's despair and appeal for pity because he could not love, (2) examination of motives in speaking, (3) a general discussion which related the themes of desire for acceptance, fear of rejection, feelings of worthlessness and desire to escape from them, and desire to be important.

Trippitt related his inability to love his girl to feelings of inadequacy. He talked about the possibility that her family might object to him because of his attendance at the clinic, then spoke of his trying to obtain mental happiness by leaning on her. (His girl was leaving town, which had precipitated the crisis.) His sense of unworthiness came out again in his deep gratitude that she should care enough about him to send him a valentine. When he couldn't love her, he felt sorry for himself and tended to "cry in the corner" because he couldn't have what he wanted.

Milton mentioned his self-consciousness about speaking in the group. He also reiterated his sensitivity to the Mental Hygiene Clinic sign, but showed increased tolerance of the disapproval of the members who had disagreed with him in *Meeting 65* (Trippitt, Gugis, and Eubank). When the group became quiet after Trippitt's discussion and waited self-consciously to see who would speak, Milton broke the silence by saying that he was speaking to please the doctor, although he had not wanted to, as it meant fulfilling Gugis' prediction. Milton derived a clearer realization of his tendency to do things because other people expected him to, which had been a serious problem in therapy.

Coombs raised a question about Gugis' attitude in predicting who would break the silence. Dr. N observed that this seemed to represent a show of superiority by Gugis. Gugis countered with the explanation: "If you have something to say, you say it." Coombs brought out that in expecting people always to act in the same way Gugis was just as rigid as Milton. The underlying theme of the discussion was whether one spoke out of a desire to speak, the need to please others, or a desire to prove superiority.

The discussion which followed combined most of the foregoing themes. Gugis showed that his reluctance to talk came from both fear of rejection and desire for acceptance. He explained to Trippitt that

one of his reasons for not speaking in the group was that people believed what he said as if he were "preaching." On the other hand, he was also disconcerted when they did not agree with him. This led to a discussion of what should be taken seriously. Gugis said he felt that only hostile thoughts could be taken seriously. He recognized that he would distrust a friendly response because of his own doubts and that this was a reason for his hesitating to talk in the group; if he said something to Trippitt, it wouldn't mean anything if Trippitt agreed.

Gugis then began a discussion, participated in by Trippitt and Coombs, about suicide. Gugis indicated that he was being supportive of Trippitt in introducing the topic and that he wanted to be taken seriously. He compared his own desire to commit suicide to Trippitt's attitude toward his girl; he thought both were seeking pity. As Gugis developed this, he brought out that for him suicide was also a way of becoming important to someone and told of his childhood fantasies of dying and in this way winning some girl. Trippitt said he felt that suicide was an escape, that in doing away with himself he would be wiping himself out of the picture and thus alleviating the situation for his girl. He agreed with Gugis that it was a way of getting pity and also that it was a way of escaping from his obligations to his girl. Coombs brought out that suicide was a way of punishing other people, because if you think they will be sorry, you must believe they love you. When Trippitt spoke of his feelings of obligation, Coombs said that, to him, this meant failing his mother. He said that when he had suicidal wishes he was revolted and felt that he was running away. As the meeting continued, the discussion turned from what made a person want to commit suicide to what made him want to go on living.

*Meeting 67.* Gugis started off with an unusually jaunty air, reporting happily a new insight which had come to him while he was walking on the street the day before—namely, that he did not have to "make a woman" in order to win her affection. He said that although Dr. N had told him this many times it had never made an impression on him until yesterday. He remained in focus for practically the entire meeting, talking of his uneasiness with girls. Instead of blaming them for being deceitful, he explored his own feelings and related his difficulties to his "stupidity" and fear of not being good at things, going much more deeply into the origin of his conflicts and recognizing for the first time the connection between his feeling of inadequacy with women and the worthlessness of the whole Gugis tribe. Others questioned him kindly and gave parallel experiences. After about

an hour Gugis indicated his desire for Trippitt's approval by saying that he wanted Trippitt to recognize that he, Gugis, had monopolized this hour, showing the effect on him of the earlier discussion about his attitude toward speaking.

*Meeting 68* revolved around fear of rejection. The discussion was shared chiefly by Eubank and Coombs, the former talking more than ever before, and more intimately. He spoke of being afraid of going to a chest doctor because he might be "bawled out," which would make him so angry that he would leave. He went on to his quarrel with his sister a year before and realized his pattern of getting angry, trying to make up, and being rebuffed. His participation may have been facilitated by the other patients' assurance in Meeting 65 that they took him seriously.

Coombs then talked for some time on fear of hostility, which he had discussed in Meeting 63. He now combined it with the theme of obligation, which Trippitt and Gugis had introduced in Meeting 64; the notion that hostile feelings are more valid than friendly ones, also introduced in Meeting 64; and the theme of unworthiness, which had emerged in Meeting 65. He related his fear to the feeling that one couldn't get affection without paying the price, which in his case meant "saying the right thing." He said that he thought it would be fine if he were to lose his wife's affection, which now spoiled the picture he had of himself as a person who brought only hate and evil into the world—a hostile person and a rejected one. He hid his hostility behind an appearance of affection. Coombs talked directly to Dr. N, but a few supportive comments were exchanged between him and Eubank.

Coombs also reintroduced the theme of relationship with the doctor as an authority figure; he described a dream in which he had been afraid of knowing as much as his father or the cardinal—who may have represented the doctor in his dream.

*Meeting 69* was shared by Trippitt and Gugis. During the first part Trippitt talked in a happy way about a visit to his home during which he had told his parents of his resentment of the fact that they had babied him. Instead of despairing, as in Meeting 66, he talked about the wild fluctuation of his feelings and of his pleasure in being able to feel warmly. The balance of his monologue was related to his feelings of unworthiness—the important insight gained in Meeting 65. He talked of his fear of being a liberal, of doing what he wanted to, of being Jewish, of being like his father, and of monopolizing the group.

Milton also happily reported signs of progress—he, who could not



argue before, had had an argument with Gugis at school about economics. This expression of friendship, however, was too much for Gugis, who expressed disgust with the argument, with himself, and with Milton. Milton subsided.

Gugis took up about half the session with his old theme of being unable to trust anyone and of his desire to love. Trippitt openly expressed his liking for Gugis. Gugis hedged about accepting or rejecting this, and then went on to talk of his fear of affection. He reported that his latest experience with the untrustworthiness of a woman had caused a less prolonged reaction than former ones. This was the theme that had been introduced by Coombs in Meeting 68. There was agreement among Gugis, Trippitt, and Milton that they were all afraid of people but in different ways.

*Meeting 70* was shared by Trippitt and Milton. Tension was at its lowest in this meeting and positive feelings were brought out most clearly. Trippitt told of having received a sympathetic letter from home—quite different from what he had expected. Milton praised the way in which Trippitt talked without his former aggressiveness. After a discussion of the change in Trippitt, the latter praised the way in which Coombs talked in the group.

Milton then talked for about forty minutes—longer than he had ever talked before in the presence of other patients—starting with the theme of fear, which had now become well established in the group. He told of trying to overcome his fear by understanding it as a savage tries to overcome his fear of a cigarette lighter by understanding how it works. He went on to his relationship with the grandmother who had raised him and his fear of blaming her, at the same time expressing a little resentment, but defending her at every turn. The problems of blame and of assuming responsibility appeared in this discussion for the first time and continued to assume growing importance in the following cycle of the group.

### *Summary of the First Cycle*

At the beginning of the cycle, patients brought out feelings and attitudes related to common concerns. Tension mounted in subsequent meetings, particularly between the two patients, Gugis and Trippitt, whose problems were most similar with relation to being unloved, and all the patients became irritable. They acted out their fear of rejection, their desire to reject others and their fear of and desire for acceptance, in the discussions of silence in Meeting 65 and of suicide

in Meeting 66. Having acted out these feelings, Gugis and Trippitt were able to go on to the painful insight that they felt unlovable, without too much fear of the group's rejection. They reconciled apparent differences in their attitudes and found a basic similarity.

Once this conflict had been temporarily resolved, the tension of the members relaxed, and they continued to elaborate their own problems as they related to this insight. The implied theme of fear of rejection was so closely related to Eubank's fear of expressing hostility because he might then be rejected that he was able to associate to it. Milton associated in much the same way. He went from his doubts about therapy to his fear of people and his attempt to analyze it and then began to express some hostility toward his grandmother. He preferred to blame himself rather than her, and this seemed to be related to his low self-esteem. Gugis progressed from talking in general of his distrust of sex and women to understanding that he felt unloved because he was unlovable in view of his feelings about himself and his family. He came to see that his distrust arose from a projection of his feeling of being deceitful. Trippitt changed from regarding sex as revolting, from distress over his inability to love and his perception of another's love for him as demanding, to recognition that he felt unlovable, to recognizing his self-pity, to a better adjustment with his family, and to revealing some of the causes of his low self-esteem. Coombs progressed from talking of his fear of hostility to realizing that he had not wanted affection and had hidden his own hostility behind the appearance of affection.

Naturally, the doctor's style of therapy played an important part in the group phenomena. In the main, Dr. N tried to bring out the emotional problems implicit in the discussion. By taking his cues from the patients and not creating diversions, he did nothing to prevent the rise of tensions and their subsequent resolution through acting out and achievement of insight.

#### THE SECOND CYCLE: MEETINGS 71-79

The themes of the second cycle were related to those of the first. There was less general examination of member-to-member attitudes, but there was an even clearer reflection of current personal problems

in the way patients attacked one another. Tension mounted as negative attitudes were expressed until Meeting 76, during which patients arrived at an important insight in relation to the themes under discussion. In Meetings 77 and 78 other members of the group applied this insight to themselves.

### *Introduction and Development of Themes: Meetings 71-79*

Although often interwoven, the following themes could be distinguished:

*Inability to handle emotional situations and emotional dependence.* (This theme included the fear of the emotional demands made by others and the desire to make emotional demands oneself—a continuation of the problem of difficulties in loving.) Coombs presented himself in Meeting 71\* as being utterly unable to handle the problem of the guilt he experienced for having accepted a university scholarship when he had no intention of going on with the type of work for which he was being trained.

Several group members tried to help Coombs handle this problem by facing the realities of the situation; their comments were both kindly and hostile. In Meeting 72† Coombs talked first of his relations with the group and then of his relations with his family; the theme of emotional dependence appeared in both. He stated that both the group and his family depended on him for salvation and could not get along without him. This attitude was also connected with his deep resentment of the group's attempt to help him face reality. In Meeting 75 he denied that he had any emotional dependence on Dr. N ("I'm not depending on him like a baby at the breast") and then went on to describe his emotional need of the doctor. In the same meeting he indicated that he had abased himself before Trippitt because this was his way of getting affection, but it had not helped, because Trippitt didn't love him anyway. When Coombs attacked Trippitt, Dr. N indicated that this attack was a displacement from himself. Coombs then attacked the doctor. Coombs continued in Meeting 75 with the theme of responsibility. He told a dream in which he had been in a store and refused to pay the bill.

Trippitt, in Meeting 71, brought up his inability to handle a violently hysterical woman whom he had seen on the street but he failed to recognize the relation between this episode and his own problem.

\*See Situation Analysis 6.

†See Situation Analysis 39.

He indicated that Dr. N's silence showed a "lack of support" and that he was looking for a response. Milton said that he would feel the same way about it. In Meeting 72 Trippitt continued with the theme, bringing out that he feared his mother's violence. He went on to his fear of anti-Semites, which involved a fear of being destroyed and was linked to his general horror of violence as well as his fascination by it. In Meeting 73\* Trippitt made repeated dependent appeals to the group for comments as he became extremely agitated over his inability to love his girl properly. He seemed to be demanding an emotional response. Gugis showed some recognition of this by saying that he thought Trippitt was not being helped enough and that some of the married men (Gugis was single) should help Trippitt. In Meeting 74 Milton also associated to this theme, saying that Trippitt's remarks reminded him that he was not able to respond to emotion in others. Eubank talked at length of the frustrating, angry relationship with his sister; he tried to force a reaction from her by ignoring her.

*Blaming others versus accepting responsibility.* Both the group situation and life situations were reflected in these themes. Feelings were expressed toward the doctor and other members of the group as well as toward persons outside the group. In Meeting 70 Milton had talked rather wistfully of not wanting to blame his grandmother. In Meeting 71, when Coombs talked about his guilt in regard to his scholarship, the question of blame and responsibility was, of course, implicit. He saw a certain advantage in hanging on to these guilt feelings. In Meeting 72 Coombs attacked Milton, because Milton, who was also a Catholic, did not feel persecuted.† This destroyed one of Coombs' excuses for remaining sick (and for escaping responsibility). Coombs later disclaimed responsibility for the attack. In Meeting 75 he was very much upset because nothing he got from either Trippitt or Dr. N gave him the answer—and the responsibility was placed on him.

Trippitt opened Meeting 73 by blaming Dr. N, saying that the latter, by telling him not to marry his girl, had totally changed his attitude and feeling. (Dr. N had not said anything of the sort.) Trippitt was deeply disturbed, and Gugis attempted to help him by supporting his attack on Dr. N. Trippitt said that the doctor had insights which he wasn't giving the patients and Gugis agreed with this; he too felt that he wasn't getting enough from the doctor. Gugis also attacked other group members for not helping Trippitt more, as if saying, "This is your responsibility." As Trippitt continued with his problem, the question of responsibility was present as a sense of obligation

\*See Situation Analysis 7.

†See also Chapter xiv, p. 312.



(which was also the problem of emotional dependence) toward his girl. Milton felt that he had the same problem, that to get love without returning it was like stealing. Gugis was irritated with this and wanted to know why it had to be repaid. In Meeting 74 Coombs attacked Trippitt by pointing out that he acted like a doctor, whereupon Trippitt elaborated on his competition with the doctor in order to rate well with both the doctor and the group. He expressed his dissatisfaction that the doctor, though omniscient, did not provide all the answers, and this meant to Trippitt that the doctor was placing responsibility on him.

In Meeting 75 Gugis suddenly said that he felt he should be punished for a letter he had written six months ago to a girl. He felt obligated to love this girl for some obscure reason. As he talked about this, Coombs suggested that Gugis wanted to love the girl but did not want to assume responsibility for doing so. Gugis again stressed his unworthiness by saying that this girl was superior to him in being just the opposite from him. He talked of rejecting her or being rejected by her. Milton then told Gugis what a fine guy he was.

Meeting 76 was the high point of this cycle because it brought together the themes with which the patients had been struggling, and it ended with a resolution of the problem of blaming others versus accepting responsibility. In Meeting 76 one patient was in focus and others associated to what he said, bringing out the following points:

1. Trippitt began by acting out his unwillingness to accept responsibility by placing his problem before the group and asking to be told what to do. He said that several months from now he would be returning to St. Louis and would be faced with the problem of whether to live with his family or not. When group members encouraged him to live away from home, he demonstrated his inability to be independent by looking for an excuse to give his family for not living with them.
2. Trippitt blamed his family. He expressed his resentment against his relatives, saying that if he were to live away from home, it would imply that they had brought him up so that he was unable to live with them- and that he would thus be making them the scapegoat for his own deficiencies.
3. Trippitt's emotional dependence on his family, which made it difficult to separate from them, was uncovered by Coombs, and Trippitt agreed that he was inventing all kinds of flimsy excuses for not leaving home.
4. The theme that separation means rejection was implicit earlier when Coombs talked of punishing the other patients in the group, who

were emotionally dependent on him, by leaving them. It was also in Trippitt's feeling that any separation from his family implied rejection by him. As he stated it, there had to be an eruption of a volcano to separate them, otherwise the question of blame would come up.

5. Trippitt also used his inadequacy as an excuse for not leaving home, as he would then be unable to keep up with his friends who were **making more money than he**.
6. Other patients participated in discussing Trippitt's problem as they felt inclined to. Coombs was particularly active in the beginning, upon the question of emotional dependence, bringing out his own emotional dependence on his family and the fact that he had to leave town in order to move away from their house. Coombs also saw that Trippitt was escaping from responsibility by blaming his family. Toward the end of the meeting Milton talked with unusual freedom of his "need to be in the shadows" because, unlike Trippitt, he felt set apart from his family. He talked again about the harshness of the grandmother who had raised him, and his feeling that he would rather blame everything on himself than on her. He saw that he had a responsibility for the effect of this on himself.

After Milton had brought out his responsibility for his own situation, Trippitt said that he did not blame his family, he saw what they had done and forgave them. Coombs brought out that what Trippitt had really said was, "On the one side of the coin they are to blame, and on the other, *I see* that they are to blame." Trippitt asked what should be on the other side, and Coombs explained, "On the other side, *I am* responsible." Coombs, laughing with embarrassment, said that the doctor had been trying to tell him this but until now he hadn't been able to see it. The whole group suddenly relaxed and laughed, as Coombs and Trippitt jointly reached the realization that it was not a question of placing blame but of assuming responsibility for one's own attitudes and behavior.

Meeting 76 is comparable to Meeting 65 in that it was the crucial meeting of the cycle. It was preceded by meetings in which the tension rose slowly as patients struggled against awareness of their responsibility for their difficulties. It was not uncomfortable, but the animated nature of the discussion indicated a considerable amount of emotional participation. Like Meeting 65, Meeting 76 culminated in insight which synthesized themes discussed separately in earlier meetings and to which different members associated in various ways in the immediately following relaxed meetings.

Meetings 77-79. Meeting 77 was entirely taken up by Guggis, who

talked on God's responsibility, bringing out more sensitive material than he had before. All his life, he said, he had endured frustrations because he felt that God was saving him for something special. Since he was waiting for this to eventuate, he had been unable to decide on a career or marriage ("It's a hell of a way to treat me"). He indicated that this was related to his sense of obligation, but the connection was not clear ("The sense of obligation makes life unbearable").

In Meeting 78 Eubank continued on the problem of his relations with his sister. This was not clearly connected with what others had been discussing but involved rejection. At the end he said that he didn't want to keep up any sort of relation with his sister.

Milton spoke of still finding it painful to blame his grandmother, but he brought out that he felt he was to blame and that he was afraid the group would blame him for things he said and even for those he had not said.

In the last half of the meeting Coombs again mentioned a dream involving responsibility. "Examining the coin with Trippitt was disturbing," he said, and he went on to tell that in the dream there had been a horrible stench connected with his refusal to accept responsibility. At the end Trippitt recognized that he had tried to place responsibility on Dr. N for deciding whether to live away from home.

### *Summary of the Second Cycle*

In the second cycle of meetings, as in the first, the patients brought out factors related to common problems, or acted out the problem with which they were involved. They were tense while struggling against recognizing that each must be responsible for his own behavior, but they relaxed after Trippitt and Coombs had verbalized the problem and the insight. Following this, several patients elaborated their own particular variations of this problem. Eubank, however, who was not very active, associated to the problem of rejection (which had also been considered by others). No insights were achieved regarding emotional dependence, and the theme was temporarily abandoned in ensuing meetings.

## SUMMARY AND IMPLICATIONS FOR THERAPY

In established groups patients tend to associate personal problems to common themes. Tension tends to rise as they act out their attitudes

in the group and to fall when insight into the nature of the common theme is achieved. The material discussed and the patients' behavior in an established group appear to be determined by common themes rather than by what patients are discussing concomitantly in individual therapy or by what is occurring in their daily lives. Thus, the form and rate of progress of patients in a mature therapeutic group are related to the properties of the group.

Rise of tension in such a group may be an indication of therapeutic progress in that it may signify the approach of an insight shared by two or more patients. The effectiveness of the doctor's interventions under such circumstances depends on his ability to sense and to help make explicit these common preoccupations as they are related to the problems of individual patients.<sup>2</sup>



## CHAPTER VII

### *Dealing with Patients in the Group Setting*

---

SINCE much of the therapy in our groups consisted of more or less prolonged discussions with individual patients in the group setting, frequent attempts were made to monopolize the attention of the doctor and the group for varying periods. When this occurred, the degree and purposefulness of the group's participation depended on the technique of the doctor, the composition of the group, and the situation at the time. If not prolonged over too many sessions, such monopolies may be of great benefit to the monopolists and other patients. They may also be among the most unsatisfactory experiences of group therapy, leading to feelings of frustration, anger, and anxiety in all concerned.

Although often appearing superficially alike, monopolistic phenomena are based on different types of relationships between patient and group. We have found it useful to distinguish two broad types, the occasional and the habitual. Certain patients may occasionally monopolize the group's attention because of pressing personal problems for which they seek the group's or the doctor's help or because situations arise in the group to which they react by compulsive talking. For example, opposition by one patient may mobilize another's need to establish the correctness of his own viewpoint, or the doctor, unaware of the pressure he is exerting, may precipitate a flood of speech. The habitual monopolist, on the other hand, feels compelled to hold the center of the stage in any group—becoming anxious when anyone else is the focus of attention. He presents problems in order to allay this anxiety rather than to get help for them. The pattern tends to be self-perpetuating, as the more the monopolist talks the more he senses

the irritation of the others, especially as he is keeping them from getting help. This makes him talk the more. He is afraid to stop for fear they will attack him, and he hopes by continuing to talk to appease or divert them. Such patients are therefore difficult to silence and tend to disrupt therapy. They are a source of irritation and frustration to the group and the doctor. We have not yet achieved sufficient understanding of this problem to deal with it satisfactorily. It may be that the chronic monopolist is unsuitable for this type of group therapy, but our experience is still too meager to warrant such a conclusion.

Not infrequently the doctor has to make a choice as to which patient should have his attention. In the following example from Meeting 48 of his Group 1<sup>o</sup> Dr. N made a fortunate choice in that other patients besides the one in focus were benefited:

Trippitt became tearful as he told how he had discovered that he could not accept affection from anyone. Milton, obviously much perturbed, tried to interrupt, but the doctor overrode him saying, "I think we had better stick with Mr. Trippitt's feelings." At the next meeting there was a general discussion of the reactions of the members to Trippitt's tears. Milton brought out that he had been so upset because of his own fear of crying in the group. He then for the first time expressed resentment toward the doctor for letting a patient break down in public. This led to a prolonged and beneficial discussion of his fear of his own emotional reactions. Other patients, linking to the topic Trippitt had been discussing, went into their own difficulties in experiencing and expressing friendly feelings.

Making a choice between two patients may, however, present an apparently insoluble dilemma, as in the following example from Dr. N's Group II. Here the doctor, after trying in vain to work with Flounder, chose to focus on Ingram, whom he regarded as more urgently needing support. Flounder's anxiety seemed to be increased by the fruitlessness of his repeated efforts to get the floor from Ingram, which the doctor blocked. His attitude also seemed to increase Ingram's constraint to such an extent that the latter derived little benefit from the doctor's attention. The doctor felt this so strongly that he asked Ingram to stay for an individual interview after the meeting. Had the doctor chosen to focus on Flounder throughout the meeting,

\*See Situation Analysis 33.

however, this would probably have been equally barren and Ingram might have been left without much-needed support.

Flounder, a semi-skilled laborer, had broken down in combat. He was subsequently demoted in rank, and from this time dated his violent hatred of officers. He entered the clinic with complaints about somatic difficulties and other evidences of extreme tension. He expressed indirectly resentment of his three older brothers, with whom he was not on speaking terms, a deep irritation with his mother's unfair treatment of him and his wife, and some annoyance with a former boss and current coworkers, who, he claimed, were always ribbing him. He said he had wanted to stay in the service. His strong impulse to kill officers, together with his inability to express directly any negative feelings toward people in his family, indicated his conflict over aggression.

An irregular attendant of group meetings, Flounder had been present at nine previous sessions. At first indirectly and then directly he had indicated his negative feelings about Bly, the only patient in the group who had been an officer. There was no evidence, such as other patients in the group gave, that he had a supportive relationship with anyone in the group, including Dr. N, who had always felt a weak rapport with him.

Ingram, the other member involved, was a very shy, schizoid patient, whose verbal participation in the group was strongly inhibited by his intense uneasiness about what others might think of him. He often showed considerable autonomic disturbance, as in today's meeting, which, in the face of his silence, made Dr. N concerned about what he might be thinking, and perhaps caused the doctor to make too much of an effort to draw him out, at least in this phase of the group.

Dr. N opened the session by commenting that he had missed Flounder for the last two weeks. After saying that he had not felt so good recently and mentioning a return of stuttering, which he had not had since he was discharged from the veterans' hospital, Flounder indicated his inability to make constructive use of the doctor's attentions to him. Asked about recent dreams, Flounder replied that he couldn't remember having had any and then became silent. Later he added that his trouble had started when he began to come to the clinic. All it had done was to work him up, and he had got nothing from it. Dr. N reminded Flounder that he had trouble getting in for meetings regularly, and Flounder said that this was right ("But all these thoughts about the hospital come back"). To Dr. N's question about the hospital, Flounder answered that some of the patients had

been beaten up but insisted he had never been; he mentioned his background in athletics and said that he was not even afraid of being beaten up now.

Flounder later talked about a recent automobile accident, said that of late he had had one every week, and explained that he had not wanted to be squeezed in against the curb and so just turned left and rammed the other car. To the doctor's question, Flounder responded that he had been afraid the other fellow was going to get ahead of him. Dr. N remarked about Flounder's "fear of humiliation," and Flounder agreed that it was "the same thing all the time." He denied, in response to the doctor's question, that he felt humiliated in the group.

Flounder then became relatively silent as Dr. N focused on Ingram's concern about school and his drive for success. When the doctor remarked at one point that Ingram could not be so dumb, since he got A's and B's, Flounder said that all he could get himself was a D. He slouched back, chewing gum and seeming withdrawn, and once looked at his watch. During a later discussion about liking school, Flounder said that he had never liked school, that education was unimportant, and that, after ten years of being out of school, he could do anything. He was fidgety.

During this colloquy, Ingram sat with his eyes shut and his face very red; he put his fingers over his eyes and became very tense. Dr. N therefore turned to him again and asked whether he was having a rough time. Ingram said that he was wondering why he had to be good. Dr. N replied that it was good to try to get these thoughts out into the open.

From this point until the end of the meeting, Flounder successfully prevented Dr. N from working with Ingram, by continually interrupting, chiefly on the topics of practical men getting ahead and of being able to get another job any time he wanted to. Ingram continued to be tense and red in the face. Dr. N told Ingram to wait after the meeting, as he wanted to talk with him while the iron was hot. Flounder left immediately and never returned to the clinic.

Flounder illustrates the pattern of the patient who seems unable to work on his own problem but feels threatened and anxious when another patient is in the doctor's focus. He was made extremely anxious by tension in other patients. He could threaten to kill officers and tell about ramming the car of a stranger, but could express only indirectly his resentment toward parents, wife, and others close to him. He became increasingly tense in group therapy, tried to deal with



anxiety by disagreeing, and could make no positive use of the doctor's attention, either when it was offered to him or after he had successfully struggled to get it.

Flounder's motive for constantly seeking the doctor's attention may have been that he felt that as long as the doctor had his eye on him, as it were, he was prevented from being destructive. The more unsuccessful he was in his attempts, the more his anger and his fear of it increased, further augmenting his need for the doctor's attention. Dr. N's interest in Ingram—particularly his offer of an individual session—may have paralleled for Flounder his parents' attention to his older brothers, which he had long resented.

It should be noted finally that early in this meeting the doctor seemed unable to accept Flounder's hostile comments. When Flounder remarked that his trouble had not started until he began coming to the clinic, Dr. N reminded him that he had trouble getting in for meetings regularly, a rather defensive response. Dr. N also failed to act in accordance with the possibility that Flounder identified the group not only with his family but with the strangers he attacked or feared to kill. Though this patient did not monopolize by talking, his compulsive need to keep others from having the doctor's attention caused him to block therapeutic progress. The issues with which he was concerned seemed similar to those of many habitual monopolists.

### THE OCCASIONAL MONOPOLIST

The conditions that give rise to occasional monopolies may be in the interplay between the doctor, the patient, and the group. The monopoly arises out of an immediate situation which is susceptible to therapeutic resolution, as is illustrated by the following situation analysis. An acutely anxious patient monopolized the meeting, was supported by the doctor and the other patients, and left considerably relieved.

#### *Situation Analysis 3*

##### **DR. N'S GROUP II, Meeting 7**

**PRESENT:** Thomas, Dupont, and Flower (40 minutes late)

**SETTING:** Flower, the central patient of this situation, was a foreign-born patient, who spoke English with a marked accent. He had always been a peripheral member of the group, although his verbal participation had tended to increase in the course of the three meetings he attended. He had been absent from the two meetings preceding this one.

Thomas had been quite dominant in the group. He was an authoritarian type of person who had been a petty officer in the Coast Guard and attributed his symptoms to his battle experiences. He was quite compliant with the doctor.

Dupont, having been born and raised in South America, also spoke English with a noticeable accent. He was preoccupied with sexual problems.

The relationship between Thomas and Dupont was complementary and easy for both, and they were comfortable with the doctor at this meeting as they talked of sexual problems and marital difficulties. At the time of Flower's abrupt entrance Thomas was talking of the three times the ship he was on had been sunk and the effect of this on him. Dupont sympathetically indicated that he could understand how "rough" it must have been.

EVENT: Forty minutes after the beginning of the meeting Flower burst into the room, coughing and wearing his pajama jacket under a topcoat. During the surprised pause at his breathless entrance, he said that he "just could not stand it last night"; he had gone over to his girl's house in the middle of the night, things had got so bad for him in his room. As Dr. N questioned Flower, he explained how bad he felt all alone in his room.

Thomas asked Flower whether he felt better when he knew people were around. Flower said he did; he felt there must be something physically wrong with him. Dr. N asked whether all this started after his war experiences—and whether he could talk about them. Flower's face flushed, he covered his face with his hands, and replied that he couldn't say.

Dr. N felt Flower's pulse, said that he was all keyed up, then left the room to get him a sedative. While Dr. N was gone, Flower said that he didn't think all this "group treatment" would help him. He didn't know what he thought. He was going all to pieces. Thomas questioned Flower about what had happened, as Dupont mumbled that it was "rough."

Dr. N returned, gave Flower a pill, and asked him what he thought might be bothering him. Flower said that he wished he knew. He had trouble finishing his classes; he was worried about his income. He got money from home, but not enough and he didn't want to ask his father for anything. He described his physical symptoms, suggesting that the cause was organic. Dr. N said that it sounded like anxiety. Flower said all he knew was that he couldn't work.

Dr. N remarked to Thomas and Dupont, "Neither of you gentlemen had similar experiences." Dupont and Thomas both said "No," but

Thomas admitted that he too had crying jags. Dr. N asked whether these had occurred after he had been in combat. Thomas said, "Yes." Flower then described some of the things he had seen in combat. Thomas said that he had had some narrow escapes too. He had been at Pearl Harbor, and he knew how awful that was. Flower looked up at Thomas. Thomas asked whether Flower often thought of those days. Dr. N asked Flower about the dates of his battle experiences. Flower was evasive with Dr. N but replied to Thomas that he did think of those days often.

Thomas asked whether anything had happened to Flower in the last twelve days. Flower brought out that he was planning to marry within a short time. Thomas suggested that Flower might be concerned about his recent drop in income. Flower agreed that this might be related. Dupont asked, "Were you afraid of all sorts of blunders while you were at your girl's house? Is her mother here?" Flower described how he had asked irrelevant questions of his girl's mother while she was telling a story that he only half heard. Dupont laughed sympathetically. Thomas asked Flower what he was thinking of when his girl's mother told her story. Thomas then asked Flower what his name was and, after a brief digression about names, told of a friend of his who came from Flower's native country. (Thomas seemed to be trying to strengthen his relationship with Flower.)

**EFFECTS:** Then he asked Flower, "Feeling better now?" Flower said, "Yes, much better." Later, when Dr. N examined with Flower his feelings about being financially dependent on his father, Flower told a bit about his family and how much it would upset him to go back home and be a dependent—although his family would be happy to have him.

At the end of the meeting, when Dr. N went off to get some more medicine for him, Flower turned toward Dupont and asked him how he had been coming along, and then talked laughingly with Thomas.

**DISCUSSION:** Flower's obvious and acute distress caused him to monopolize the group and won him the interest and support of the other patients. The other members, habitually deferential to the doctor, hung back until the doctor indicated his willingness for them to participate. Their support, offered in terms of comparing experiences, seemed more effective in allaying Flower's anxiety than the doctor's questions and comments had been. Flower finally relaxed sufficiently to be able to discuss a psychodynamically important issue with the doctor and left the meeting apparently much relieved.

**TENTATIVE DEDUCTION:** This monopoly was apparently facilitated by

the patient's obvious need for help and by the fact that he brought up problems which also concerned the other patients and with which they were able to help him.

In the following case a patient arrived at a new insight by working for some time on a problem of real concern to him and other group members with the help and encouragement of the doctor and group.

#### *Situation Analysis 4*

##### **DR. N's GROUP III, Meeting 18**

**PRESENT:** Minor, Bridges, Stone, Cann, and Alban\*

**SETTING:** All the patients except Alban were concerned with problems of domination. Minor and Bridges were in conflict over their struggle to dominate the group. Both were overtly aggressive and tended to use as a defense the appearance of having everything under control. This similarity had led to irritation with each other. Minor tended to alternate between giving advice to others and retreating with smiles and apologies. The group members were dissatisfied with their therapeutic progress and critical of Alban for his repetitious presentation of his sexual problems.

At this meeting Minor expressed his fear that the Navy might gain access to his clinic record, and this led to discussion of his concern over how his service experience might have affected his future, which aroused the interest and participation of the others. Bridges, for example, said, "Most of us had the props knocked out from under us; the best years of our life were taken." Cann later repeated Bridges' phrase, saying to Minor, "Something you said about your childhood at a previous meeting gave me the impression that you felt the props were knocked out then." When Dr. N proposed looking into Minor's concern about the future, Stone said, "I think anyone worrying about the future should have a reason for doing so."

**EVENT:** Then for three-quarters of an hour Minor talked about his war experiences, which he had never been able to tell to anyone other than a doctor. He had asked for transfer from his PT boat crew, who along with his replacement were killed on the next trip.

As Cann and Stone made occasional sympathetic comments throughout, Dr. N helped Minor to realize that the other men in the ill-fated crew had had a part in his getting transferred and to admit that he had wished that the boat would be sunk. Bridges described what he said was a similar feeling, but when he tried to continue, Dr. N kept

\*For the psychodynamics of these patients see Chapter IV.



his attention on Minor, who went on to tell how originally he had antagonized the crew by driving them and then he tried too hard to make friends with them, by taking the attitude, "I'll leave it up to you—when do you think we should go over the engine?" However, the men still disliked him. Dr. N wondered if Minor really hadn't been crowding the crew in some way.

EFFECTS: Minor paused and then said laughingly that if the men had shore leave in the afternoon, he would give them a choice of going over the engine in the morning or afternoon. Minor realized that he had not really abandoned his efforts to control his crew and this seemed to be a new insight.

At the next meeting Bridges talked about his attempts to get his parents to act in the way he wanted them to, and later in the meeting Minor was able to see the problem as attempting to control others while believing oneself to be helping them, and expecting gratitude in return. Minor found that he did this with his family just as he had done it with his PT boat crew.

DISCUSSION: Minor's great anxiety and need to speak were apparent. He received sufficient support from Dr. N and other patients concerning his uncertainty about the future to enable him to go on to the more acute issue of his traumatic Navy experiences.

The fact that he had been somewhat self-revealing in earlier meetings and had derived some benefit from this may also have facilitated his talking about this extremely sensitive topic. The doctor encouraged his monopoly, and the group concurred, because he was obviously upset and not trying to dominate, and because insecurity about the future and antagonizing others through attempts to dominate them were topics of common concern. In addition, Minor's monopolizing automatically cut out two other potential monopolists, Alban and Bridges, both of whom had recently held forth at length in the group without making therapeutic progress.

Minor was able to verbalize death wishes toward his crew, and possibly got a glimmering of how this might relate to his guilt. He saw for the first time how he had never really abandoned his attempts to dominate and the relation of this to others' antagonism. At the next meeting both he and Bridges were able to associate usefully to their attitudes toward their families.

By acting out his conflict over domination in the group, Minor had demonstrated that this was a genuine problem and not just an effort to gain attention on a particular occasion. A clue that a problem expressed by a patient is important to him is the fact that he has demonstrated it by behavior in the group.

In the following account a patient who had a pressing problem, which was also of importance to the group, was encouraged by the doctor and supported in his monopoly by the rest of the group. Tension had been rising in anticipation of intra-group conflict, but as a result of the monopoly the group became less tense and the patient gained increased insight.

### *Situation Analysis 5*

#### **DR. K's GROUP, Meeting 24**

**PRESENT:** Rothschild, Turner, Mulican, Sloane, Mercer, and West

**SETTING:** The doctor tended to intellectualize problems and tried to conceal his often intense feelings in the group. He was wary of frank or strong expression of hostility. The group was composed of rather obsessive, intellectual patients, with a low capacity for tolerating tension. Almost all had fears of homosexuality. Turner was a highly intelligent patient, an accountant, with a homosexual bent. He was somewhat resistant to revealing himself, but frequently was helpful in his clear perceptions and therapeutic insight into others. Mulican was a big, bluff, excitable man, very masculine in type, who had upset the group considerably at the previous meeting by attacking the doctor and the group for non-therapeutic behavior. He was now somewhat discouraged with his prospects for therapeutic success.

Early in the meeting West and Mercer discussed Mercer's keeping a diary, which made him feel "girlish." Turner refused to be drawn into the discussion, saying that he had his own problems and wasn't listening very well. Then West discussed his passivity in sports, as related to the problem of his masculinity. Mercer and West expressed concern over what Mulican thought of the conversation. Mulican quietly but menacingly suggested that all of it was irrelevant. He then tried to urge a questionable and superficial sort of optimism on the group. Turner sniped at an inconsistency in Mulican's speech. Mulican became defensive, declaring, "If I could figure it out, I wouldn't bother to come down here." Dr. K and Turner tried to withdraw from the semblance of an attack on Mulican.

When Mulican spoke casually of last week's encounter, the tension seemed to ease briefly and West and Turner were able to attack him when he referred pleasantly to the "good old days." Turner declared, "He's setting himself apart," and despite the doctor's and Rothschild's efforts to smooth things over, Mulican gave a fifteen-minute lecture in favor of the "moral virtues." Dr. K finally had to ask whether Mulican felt that he was "being himself" and this, with some comments by West produced another minor explosion in Mulican.

**PRECIPITATING EVENT:** Dr. K turned to Turner and remarked, "You didn't talk about your problem." At first Turner said that he felt that he might save it for a private hour, but then Mulican joined in, trying to overcome Turner's resistance to talking in the group.

**EVENT:** Turner spoke freely for thirty minutes about inquiries that were being made about his possible homosexual tendencies. The doctor treated this as a reality problem. Other members of the group commented, as Turner and his feelings remained in focus.

**EFFECTS:** The members of the group expressed a common resentment against Turner's antagonists, as well as sympathy for his position. There was a general resentment against the system that produced this sad state of affairs. Mulican felt that Turner should have taken his satisfaction "on the spot." He insisted that attempts had been made to coerce Turner into "admitting it." He was irritated at "world tendencies that a man is guilty until proven innocent." The group deferred to Mulican's louder voice and appeared to be in sympathy with his sentiments. West asked very fearfully about the "Government's attitude on morals" and was frankly upset and angry, as was Mercer. The doctor did not hide his feeling that an injustice existed. The intra-group hostility that had existed earlier was now re-directed against the common antagonist.

Turner was able to express some of his feelings and examine his reactions to such situations. He was able to see his inability to accept some of his old feelings. He also could see his delay in becoming angry at the inquiry as a manifestation of his fear of expressing anger and of the punishment that might ensue. Only when supported by the others could he express his desire to "beat up" the informer. At the next meeting there was a fairly frank discussion of homosexuality.

**DISCUSSION:** In this situation, a concern which had been active in the group was blocked by the challenge of a very threatening member. West and Mercer were concerned about masculinity and girlishness, suggesting some homosexual fears. Mulican, however, challenged the group's behavior as "irrelevant" and said he got nothing out of it. This challenge, plus the threat of Mulican's previously demonstrated explosiveness, heightened the tension in the group until all of the members, after the doctor's intervention, were willing to attend to and rally around Turner's problems. This was a continuation of the previous discussion about homosexual fears. Even Mulican was able to join in, for it permitted him to direct his hostility against injustice rather than examine his own feelings.

**TENTATIVE DEDUCTION:** One patient may be permitted to monopolize group time and helped to work through his difficulty when the problem

is urgent and the topic is of importance to the group. This monopoly of the group's attention may be a useful way of relieving intra-group tension and increasing group cohesiveness.

The following account illustrates how monopolizing on a subject of concern to the group was therapeutically beneficial when the doctor encouraged the group to help the patient see his distortions.

### *Situation Analysis 6*

#### *DR. N's GROUP I, Meeting 71\**

PRESENT: Coombs, Trippitt, Milton, Eubank, and Gugin

SETTING: The group was in a phase of relaxed and supportive relationships, in which each patient could discuss his own problems at length. These involved dependence, gratitude, and personal responsibility. All except one of the patients had talked about their conflict over their emotional dependence on the doctor.

Coombs was a very verbal patient who tended to comply with the doctor by examining his feelings, and who made himself interesting by presenting very vivid experiences, emotions, and fantasies in a rather baffling way. He had had many helpful emotional experiences brought about by what happened in the group.

This meeting started in a rather desultory manner, no one wanting to talk. Coombs, under strong emotional pressure, then proceeded to speak directly to Dr. N for about twenty-five minutes. He referred to his feeling, discussed in an individual session, that his family had deserted him and its relation to his experiences at the university. When he had gone away to school at sixteen, it had seemed like a deliverance from home. At the end of the second year, he realized that he wanted to get out, but he stayed on for several years more. He felt that he had exploited the system by accepting a free education. Now he was falling down on his contract and his sponsors were waiting for him "to pay." He stated as his problem, "How to let them know that I was an s. o. b." He said that he had wanted to get out of the university without taking the responsibility for leaving.

When Dr. N asked about his feeling that he had been trying to get away from his family, Coombs said that he felt he had no right to be freed from them. He felt that he would have to apply his own punishment and that the authorities had always known he would. With increasing emotion Coombs elaborated on his sense of guilt in having accepted so much from the university and from friends. Dr. N

\*See Situation Analysis 39 for Meeting 72 of this group.



asked if Coombs had thought of financial restitution to alleviate his feeling of guilt. He gave superficial reasons for not doing this and then asked Dr. N whether he thought the problem would be solved by paying money. Trippitt added that Coombs was placing responsibility on the doctor. Dr. N suggested hearing from the others.

**EVENT:** Milton replied at some length, saying that Coombs was exaggerating the whole thing and that others had accepted scholarships under false pretenses. Trippitt suggested talking the matter over with the president of the university, and when Coombs expressed exaggerated fear of this course, Trippitt pointed out that "the president is not God." Gugin started an argument with Coombs about whether the latter could ease his own pain by blaming others for what he had done.

**EFFECTS:** Milton in particular benefited from this session. From the discussion of facing reality, he got the idea, "Grab what you're afraid of." Subsequently he visited his grandmother, whom he feared, and found it easier than he had expected. He also faced his fear of illegitimacy by searching the records and discovered that he was legitimate.

In subsequent individual and group meetings Coombs brought out his anger and feeling of rejection—the group was his family and was going to cast him out. He then realized that he wanted to be thrown out, because this would punish the others, who couldn't do without him. He realized that he had "worked" people all his life by appealing for pity and now saw that it didn't succeed, since neither the doctor nor the group had given him pity but had encouraged him to accept responsibility for what he did and to face reality. By Meeting 76 he was able to see that he was responsible for his life predicament.

**DISCUSSION:** This situation grew out of events in both individual and group sessions. In individual sessions Coombs had been coming closer to understanding his desire to escape from reality and responsibility and to his resentment and feeling of rejection when Dr. N, instead of pitying him, indicated that he expected him to work out his problems.

The current theme in the group also involved responsibility. It may be that seeing other patients face the same problem had made Coombs all the more anxious. His anxiety took the form of exaggerated feelings of guilt, which he presented to the group in a way calculated to elicit pity. But instead of pitying Coombs, the other patients helped him correct his distortions by demanding that he face reality. In doing this they followed the example of the doctor, who had suggested a possible realistic solution. As a result of extensive previous experience with Coombs' emotions, they were not taken in by his appeal. The

problem which Coombs presented had been previously discussed by others in the group. Its consideration took place at a time when tensions in the group were relaxed, which seemed related to the fact that the group had been able to allow one patient to be in focus for extended periods.

**TENTATIVE DEDUCTION:** A sudden monopoly may indicate that current themes have touched on and brought to the surface a basic neurotic pattern which the monopolist shares with other members of the group.

In the following example a patient talked about an acute phase of his central problem with other members of the group, effectively discussing the aspects related to theirs with help from the doctor.

### *Situation Analysis 7*

#### **DR. N's GROUP I, Meeting 73**

**PRESENT:** Coombs, Eubank, Gugis, Milton, and Trippitt

**SETTING:** Relationships in the group had been relaxed and supportive for several meetings, but tension was beginning to reappear. The content had included problems of loving and dependence. The protagonist, Trippitt, had been very active in participating in discussions. He habitually handled his anxiety by retreating into intellectuality and arrogant superiority, which infuriated the others. They attacked him with the implication that, if he dropped this kind of behavior, they would like him. He then realized that he was suspicious of people who liked him because he felt that they were fooled by his front.<sup>1</sup> From this point he had presented more deeply emotional problems, particularly his desire to be able to love, and the group had related to him more positively. Gugis, for example, had explicitly stated that Trippitt's problems were his own and that he therefore wished Trippitt to discuss them. Milton, in Meeting 70, had praised the change in Trippitt, because the latter now spoke with "less drive" and created less of a "kick back" in Milton.

Trippitt had been concerned because his girl was dependent, like his mother, and had seriously doubted whether he should continue his relationship with her. He had also been disturbed because he had the least feeling for her when he made love to her, and because of his inability to cope with an emotional woman. Love as a burden to the loved person had been of concern to Trippitt in several meetings and also to Gugis and Milton.

**EVENT:** Trippitt began to talk with considerable feeling, almost

before the group had assembled. He related that in individual sessions he had told Dr. N he was going to ask his girl to marry him and that the latter "like an archbishop, had replied, 'I wouldn't marry precipitously.'" He then became indifferent to his girl, who was to visit him that day. Although he was supposed to be in love, he couldn't feel anything. He finally cried, as he built up a picture of himself as a frustrated man.

Dr. N recalled that in the individual session it was Trippitt who had said he doubted whether he should marry, pointing out that it was significant that Trippitt was trying to pin this idea on the doctor. Eubank brought out that Trippitt needed the doctor's approval before doing anything, and that he was turning down his girl because he thought the doctor wanted him to. This led to a discussion of Trippitt's relationship with the doctor, his feeling that the doctor was omniscient, his need for the doctor's opinion to support his own, and his insecurity and inadequacy as related to his inability to love.

Trippitt said that after the last individual session, when he had been looking for a warm and fatherly feeling, he had felt that the doctor was being coldly scientific. He recalled that his father didn't give him the love he wanted and he saw that he was carrying the feeling from his father over to the doctor. He then went back to the fact that nothing had as much "import" to him as the question of his ability to love or not love this girl—"It is the focus of therapy for me." He told of thinking that his problem would have been solved if a train accident had killed her, and how he practically cried in the group on remembering this. As the group remained silent, he asked appealingly, "Still no response from the gallery?" Dr. N observed that others might have something to say about guilt.

**EFFECTS:** The patients discussed facets of Trippitt's problem which were related to their own, helping him to see the problem more clearly and realize why it was so necessary for him to love his girl. Gugis said that at least ten times he had thought of something to say but had been afraid that what he said wouldn't count. Difficulty in making a decision was a problem for him as well as for Trippitt and he would like the doctor to do it for him; what the doctor said would carry more weight than his own feelings. He expressed dissatisfaction over the progress he had made in therapy and said that he thought Trippitt had good reason for feeling as he did. Trippitt continued to discuss his feelings with the doctor, finally bringing out, with tears, that he needed to love because "it gives a direction in life." He talked of owing love to his girl as a debt, and as something he wanted to do—

"What makes it so terrible is that it's so easy for other people to do." Eubank made a reassuring comment.

Milton said the discussion had made him see that he also had the attitude that if he didn't do things for others he would get no love from them. Trippitt said that he had his girl's love but the responsibility for reciprocating her passion made it a millstone.

Gugis complained that the people with experience (i.e., the married men) did not speak up. Coombs—who was married—replied that he didn't see how this would have any bearing. Gugis said that he himself had a go-to-hell attitude, that he was angry—"Why don't people help Trippitt out?" This was followed by further discussion of Trippitt's problem with some recapitulation of the points previously made.

Trippitt, at the end, saw the parallel in his relationship to his girl and to the doctor, both of whom were necessary to give meaning to his life.

DISCUSSION: Although Trippitt's problem was accentuated in Meeting 73 by the fact that his girl was on her way to see him, it was also related to previous concerns of the group. Since the early meetings the group had demanded that Trippitt show his feelings about his problems, and from time to time he had done so. Trippitt's problem of dependence was also common to Coombs and Eubank. The group, particularly Trippitt and Gugis, had discussed in previous meetings problems about loving.

The fact that aspects of Trippitt's problems were shared enabled the group to participate in the therapeutic process, while Trippitt was in focus. It enabled the group to keep him in focus and enabled him to express his feelings about his problems and move toward their resolution. It helped Coombs to recognize that he needed to love to give meaning to his life. It helped Gugis to express dissatisfaction with the doctor and the group, which had been difficult but important to him. Milton, who was slow in gaining insights, now realized that he had to do something in order to be loved.

TENTATIVE DEDUCTIONS: There seemed to be a connection between the following factors. A patient who had established a relationship with the group became very anxious over a reality situation; the group supported him and were able to help him with his problem, some aspects of which were familiar to them in their own lives and through previous discussions; the doctor gained insight into the patient's distortions and gave a clue to them.

Congruities between situations which elicit certain feelings outside



and within the group may give valuable clues to the basic neurotic conflicts underlying both. This congruity enables the patient to gain insight by acting out the problem in the group.

The following situation analysis contrasts with the preceding ones in that the doctor's concentration on one patient led nowhere because the patient was out of touch with the group and had no urgent problems. He monopolized at the doctor's invitation.

### *Situation Analysis 8*

#### *DR. N'S GROUP I, Meeting 57*

PRESENT: Coombs, Gugis, Eubank, Milton, and Ransom

SETTING: Ransom, the monopolist, suffered from anxiety attacks. He had been concerned chiefly with questions of marriage and career and had indicated that he felt superior to the rest of the group and more deserving of the doctor's attention. He had been discharged as improved after Meeting 42. Since then the group had moved to other topics and had become more able to express and study their feelings.

In Meeting 56 tension arose when Milton indirectly attacked what he felt to be Dr. N's dictatorial manner. The group persistently tried to get him to express his irritation more directly and examine it, as he denied that he was irritated. Gugis sided with Milton, who became quite upset, and the meeting ended with the tension unresolved.

EVENT: Ransom unexpectedly appeared at Meeting 57. When Dr. N asked him why he had come, he spoke about his courses at school and the advisability of changing his field of concentration. He said that he had planned for a long time to come in—partly to talk out the question of getting married, although he realized that he had to figure it out for himself. Dr. N asked whether other members of the group had any comments on this; there was general silence. Dr. N then asked Ransom about his physical symptoms, which the latter said had just about disappeared. He then told of anxiety dreams. He continued talking about changing his career from law to architecture, and the doctor turned to Gugis for his opinion. Gugis thought that architectural engineering would be a shorter course. The discussion then continued between Ransom and Dr. N on sexual problems without further participation from the group. Throughout, the group seemed bored and ill-at-ease and lacked its usual cohesiveness. After about twenty minutes, Dr. N commented, "Pretty good progress report."

EFFECTS: Ransom did not seem to gain anything from his monopoly and did not return to the clinic for about a year, when he saw Dr. N

once privately. The group did not become interested until Milton, at the invitation of the doctor, began to speculate about what had made him so angry at the last meeting. An animated discussion of anger and fear developed, in which Ransom made the only one of his contributions that was accepted by the group, when he talked of the fear that if you blow your top something will get out of control.

DISCUSSION: Ransom returned to the group after fifteen meetings. He presented a problem at a level that the group had gone beyond. The superficial feelings that he expressed were out of keeping with the emotional tension of the group. Although the other patients deferred to Dr. N, who focused on Ransom, he was an intruder, whose monopoly did not arouse their interest. When Ransom contributed to the discussion of expression of anger, he seemed to be more acceptable as a member of the group.

TENTATIVE DEDUCTION: When the problems presented by a patient who monopolizes the doctor's attention do not appear to be pressing and are out of key with the mood and preoccupations of the group, the discussion gets nowhere and the group becomes bored.

Table 7 summarizes Situation Analyses 3 to 8 inclusive, to bring out common factors in occasional monopolies which seemed therapeutically useful (Situation Analyses 3-7) and the contrasting features of one that was not (Situation Analysis 8).

### SUMMARY AND IMPLICATIONS FOR THERAPY

The effects on the other patients of the doctor's concentration on one is a problem obviously peculiar to group therapy. The successful solution of the problem seems to be related to the doctor's awareness of the others and the way they are reacting, so that he can bring them into the discussion or make a comment when it is appropriate.

One determinant of the occasional monopoly is the mode of procedure set by the doctor. All our doctors focused attention on individual patients at one time or another, but with different degrees of concentration and for varying periods.

Another determinant is the patient's need for help with a problem. The pressure of his anxiety—whether neurotic in origin or arising from an acute practical problem—may prompt the doctor or the other patients to encourage him to talk. This is particularly true when some members of the group are involved in the problem presented.

We found that the following conditions seemed to contribute to the therapeutic usefulness of this kind of situation:

1. When the tension rises and the discussion is blocked, the doctor may help the group as a whole by focusing on one patient who has a problem with which all or most of the other members are concerned.
2. If the topic of the monopoly is a problem which is of obviously deep and pressing concern to the patient the interest of the group may be aroused, even though the patient has been only a peripheral member and his topic is not of immediate concern to the others, as in Situation Analysis 3. The ability of the group to support a disturbed patient in monopolizing attention, despite the fact that the subject is not of personal concern to them, is an indication of maturity in this regard. Therefore, it is not necessary for the doctor to interrupt the monopoly out of concern for the others. Usually, however, therapeutically useful monopolies involve patients who have been participating in the discussion of mutual problems.
3. The group or the doctor may encourage a patient to monopolize the discussion as a means of preventing another patient from talking about subjects which create more anxiety in the group or doctor or both than they can tolerate at the time (see Situation Analysis 5). This may be an unconscious maneuver. The doctor must be on guard not to project his own anxiety on the group, which would lead him to terminate an expression of feeling that the group was ready for (see Chapter xv). Conversely, he should keep in mind that the group's anxiety may be concealed behind an air of boredom and may actually be sufficiently strong to cause the patients to shut out the implication of what is going on.

Groups may be more able to accept the doctor's interest in a particular patient in late meetings than in early meetings, for as therapy progresses patients see relationships to their own problems more readily. But, in any group in which rivalry is strong the doctor should keep in mind the possible implications of focusing on an individual patient's problems from the standpoint of competition for his attention. The doctor's concentration on one patient is likely to be fruitless if the lat-

rent

lier,

t to

be

age

tate

on

ave

we

ents

in

ued

tain

ptic

ans

are

their

ten

no

man

stic

ion

may

trial

ms

the

ete

ars

ure





ter's problem is a superficial one and is not in keeping with the current mood and preoccupation of the group (see Situation Analysis 8).

### THE HABITUAL MONOPOLIST

The essential feature of the habitual monopolist, as stated earlier, is his neurotic need to be the center of attention. He is difficult to work with because the topic of his monopoly is more likely to be one which he thinks will enable him to keep the center of the stage than one which is closely related to his problem. The present state of our knowledge does not permit more than a few observations on the psychodynamics of these patients and the ways in which we have handled the situation with temporary success. For comparison, we have also included examples of our failures. Those of our patients who have improved appear to have made their chief progress in individual sessions. Two eventually left their groups and continued with individual treatment.

#### *Personality Characteristics of Habitual Monopolists*

In studying the psychodynamics of the habitual monopolist, certain trends seem to be frequently present. (In this discussion, the psychotic monopolist is excluded.) All are skilled in the use of words as a means of controlling others and allaying their own anxieties. Many are obsessional, but much of their anxiety is near the surface, and their obsessional defenses do not work very successfully. Stutterers often prove to be habitual monopolists—especially if the group contains no others similarly afflicted. We have had no experience with more than one stutterer in the same group at the same time. The monopolistic pattern frequently seems to involve a conflict between submission and dominance intermingled with anxiety and guilt. The patient may seek the doctor's attention in a submissive way by presenting material he thinks will win sympathy or interest. At the same time, he seems to be trying to control the doctor and the group. Sometimes the patient seems to feel that as long as he can keep the doctor's complete attention he can prevent the discovery of attitudes for which he fears punishment. He must keep continuous control of the doctor's picture

of him and must know the doctor's attitude toward him at all times. One such patient sat on the doctor's left, around the corner of the table; he explained that from this spot he could constantly watch the doctor out of the corner of his eye without the latter's being aware of it. In addition to the underlying fear of discovery there is the fear that the authority figure will catch on to the fact that he is being manipulated and that the other members of the group will become angry at the monopolist's cutting them out. The roots of the pattern are not clear, but in at least three cases the physical violence of a parent had been feared and the patient had apparently relied to some extent on his verbal dexterity and quick-wittedness to protect himself. The introduction of a new member, constituting a new threat to the monopolist (as in Situation Analyses 10 and 11 below) seemed to make the dominance-dependency conflict acute, leading to an aggravation of the pattern of monopolizing. A related characteristic seen in many habitual monopolizers was sado-masochistic character organization, which led them on the one hand to bully, and on the other to invite punishment in the form of ridicule and contempt.

We were struck, finally, by exhibitionistic tendencies in some, but not all, habitual monopolists; on occasion these dovetailed with voyeuristic tendencies in other patients, so as to perpetuate the monopoly.

### *Aspects of the Monopolistic Pattern*

Characteristically, the habitual monopolist gets caught in a vicious circle. He starts to talk in order to deal with a tension which has been created in him by the group situation. As he talks, he becomes at least dimly aware that a component of his purpose in doing so is to dominate the others, or at least to cut them out. He also senses their growing irritation. The result is that he feels increasingly guilty and anxious and finds it still more difficult to relinquish the floor, and his anxiety increases his tendency to ramble and to confuse his statements. He may even forget what he started to talk about. Certain phenomena which are useful in identifying this pattern relate to the fact that the patient's chief motive in talking is to hold the center of the stage rather than to get help. He tends to seize any pretext, relevant or not,

for getting the focus of attention and to fit from topic to topic as in the following example from Dr. N's Group II.

In Meeting 64 Ingram started off with a discussion about psychiatrists' inability to agree on the merits of group therapy, adding that this supported his own doubts. Bly, the habitual monopolist, agreed, then immediately shifted the topic to his own inferiority feelings, which he discussed for some time. Ingram discussed his inferiority feelings, and although Bly interjected a statement occasionally, Dr. N continued to question Ingram directly. After Ingram had been in focus for a few minutes, Bly said that he knew how Ingram felt and that his own case was just like Ingram's. Bly made repeated references to himself as "just like Ingram," but the group remained focused on Ingram. Coombs, Veal, and Dr. N all questioned Ingram about his inferiority feelings when with girls, which Ingram had said was a big problem. Bly then presented a rather garbled parallel to Ingram's story—he began to talk about a girl he had known before he was married and his family's reaction to her, but ended up by talking about his cold, reserved mother-in-law. Bly apparently recognized his irrelevance. He stopped himself and laughed, asking, "Now, how did I get off on that topic?"

Once such a patient has the focus, he tries his best to keep it. He may seek to do this by presenting material which keeps the others confused, by presenting bizarre or sensational material, or by dramatizing his difficulties, as illustrated in the following example, which also shows the futility of asking the patient why he talked so much. Since this is a neurotic manifestation, the sources of which are at least partly if not entirely unconscious, the best the patient can do in such circumstances is to reproach himself, as in the following example from Dr. K's group.

Malta, a stutterer, talked at great length of his sexual urge and his relations with women. He agreed whenever another patient offered interpretations, and in associating he brought up several "shocking" sexual experiences that he had mentioned many times before (this patient also illustrates the exhibitionistic nature of some monopolists). When Dr. K tried to evoke Malta's feelings, he repeated his usual self-depreciatory remarks. Another patient then asked for further incidents, which Malta supplied. He continued to monopolize to the end of the meeting, with no one apparently making any therapeutic progress.



*Dealing with the Habitual Monopolist*

The ultimate goal of treating the habitual monopolist, as of treating any other patient, is of course to help him resolve his conflict and its attending anxiety, so that he loses the symptom. We were not able to solve this problem. In no case did a chronic monopolist completely give up his pattern, and many of the interventions which stopped him during a meeting did not benefit him. On the contrary, they sometimes left him more anxious and tense. It was necessary, however, to try to interrupt these patients in order to give the others a chance. However, we do have some clues as to what might be helpful as a basis for further study.

Certain techniques have been found to be regularly unsuccessful. As illustrated above, asking the patient why he talked so much proved useless. A non-directive approach, in which the patient's words were reflected back to him by the doctor, was also ineffective. It did not relieve his anxiety, and so put an end to his compulsive talking, nor did it offer him escape through association, since the monopolist is not primarily interested in content—in fact, the content of his remarks is often irrelevant to his need to monopolize. Ignoring the monopolist or pointedly calling on another patient to speak usually proved ineffectual because it aggravated the monopolist's anxiety and hence his need to dominate the situation by holding the floor.

In all the temporarily successful interventions in our series, that is, those which stopped the monopolist and led to something fruitful either to him or others, the interventions intensified the reality aspects of the situation. In one way or another they brought the patient up short, cutting through his vicious circle of compulsive speaking and mounting guilt and anxiety and helping him to see the meaning of his behavior in relation to the other members of the group. In all cases the doctor's intervention had a directive quality.

Sometimes the monopolist achieved useful insight when he was set a very definite, specific task involving close examination of an aspect of his daily life which the doctor believed to be related to his monopolistic behavior, as illustrated by the following example from Dr. R's Group 1. In this case little progress was made by examining the content

of the patient's remarks. Finally, when the doctor pinned him down to a minute-by-minute report on what had been going on in his office, he became aware of his continual competitiveness, and the way in which this was related to his monopolizing. The significant feature seemed to be that the doctor gave the patient a task with which he could come to grips.<sup>2</sup>

Scuffy repeatedly brought up difficulties with his boss, who he said was hypercritical and inconsiderate and whom he identified with his father and brother. With the help of the other patients and Dr. R over the course of many meetings, Scuffy worked on this identification with the result that he relaxed somewhat in the group. At the conclusion of one session, Scuffy fantasied sucking his mother's breast with his father glaring at him; he concluded the fantasy by striking his father. He then spoke of his boss as one who, like his father, would rob him of his security—that is, of his position as a book-designer. After expressing resentment toward his boss, he said that he felt he would be able to deal more frankly with him in the future. This proved to be true, but it made little change in Scuffy's general tension. He reported later that the relaxation he obtained by working on his problems in the group had had very little carry-over.

To explore the subject further Dr. R recommended that Scuffy give the group a minute-by-minute report of what happened in the office during the day. Scuffy protested that he didn't see much point in doing so, but complied. He began, "I hate to get at my desk in the morning. I know it's just the beginning of another day of frustration. The guy next to me goes along smoothly with his work. I struggle and struggle. Sometimes I think of asking him to help me with my technique, but that would be admitting I don't know anything. I think the people I work with think that anyway. I say to myself, 'If I could relax, I'd show them!'" Scuffy thus opened up the deep-seated problem of his competitiveness with peers and his feelings of inferiority, as shown by the unfavorable comparisons of himself to others. These problems were gone into with the result that he became more at ease at the office and even experienced occasional comfortable days.

Later, Dr. R and Scuffy recognized the hidden significance of Scuffy's monopolistic talking. He needed to show the group that he was capable of doing a more thorough analysis on his problems than they were. The temporary relaxation that the patient experienced at the end of each session seemed to be the result of the demonstra-

tion to the group of his apparent superiority in self-analysis, and not the self-analysis *per se*. The content of his statements in the group served his neurotic needs rather than therapeutic ends.

A more common temporarily successful intervention was to call the patient's attention to the meaning of his behavior in the group.<sup>3</sup> This was sometimes done bluntly by a direct interpretation of the monopolist's behavior. There was the danger, of course, that the interpretation might be wrong. Stopping the monopolist might increase the tension of the group, if his monopoly served a purpose for them. When the interpretation was successful, however, it might enable the monopolist and others to associate usefully to it, as in Situation Analysis 9, when the doctor called the patient's attention to the feelings he expressed at the time he started to monopolize—that is, his conflicts about silences in the group.

### *Situation Analysis 9*

#### *Dr. Z's Group, Meeting 40*

PRESENT: Giordano, Stafford, and Phillips

SETTING: The mores of this group encouraged patients to talk about their personal life. This developed from their tendency to argue about "who's holding back." All had expressed feelings of having fallen short of what was expected of them as men. Presentation of ordinarily taboo material had been a way of competing for status in the group, and in the past the doctor had pointed it out as a way of putting on a good group meeting for him before the observer.

Stafford, who tended to monopolize, always understated his feelings and avoided their analysis by describing seemingly significant events. He had a very unclear picture of relationships with equals but usually tried to respond to their remarks with helpful suggestions or competitive examples, in accordance with his aim to be a good patient. He said that one "pours on personality" by doing something obviously correct, such as being helpful, as a basis for getting the regard of others. In contrast to the other two patients, his association led him away from the emotional implication of what he was saying.

Giordano, who had been psychotic, usually spoke in terms of vague feelings to which he associated other feelings that he rarely tied to events. He complained of being made anxious by people, such as Stafford, who gained attention with a well-told anecdote.

Stafford started this meeting after a brief silence by saying that

he had a problem, but hesitated to go on because of the microphone. He then started to tell an anecdote, which lasted about twenty minutes. This revolved around his feelings of embarrassment and guilt about being seen riding in the bus or eating lunch with a girl at his office with whom he was having sexual relations.

When the doctor remarked, "Well, in any case you seemed to find some reason to be embarrassed or ashamed," Stafford replied evasively, "In the last couple of days that's disappeared." He then launched into an account of how it did not bother him to date the girl when he knew his colleagues esteemed her—that is, he denied the importance of his feeling by presenting another example in which he had no significant feelings.

EVENT: Dr. Z, having at a previous meeting had similar lack of success in getting Stafford to associate to his feelings, reverted to examination of what had actually happened in the group: "You thought about bringing this up in this session."

EFFECTS: Stafford replied, "I noticed everybody was silent, and I thought about the 'mike.'" Dr. Z: "I wonder about your thought 'things were silent.'" The patient, in accordance with the custom of this group, accused himself of wanting the spotlight. The doctor tacitly rejected this by continuing to remind him that he said he felt that things were silent. Finally, the patient added that he had to search his mind for something to say. The doctor pointed out that quietness does not necessarily carry that obligation. Then he asked, "Is this part of putting on a good group meeting for me since the other two are silent?" Stafford promptly denied this, then added that he felt irritated with the other two for not saying anything, and he recalled often feeling this need to say something at the office, or on the bus, or on a date—"I sort of feel that I'm falling down on the job." Dr. Z suggested that Stafford might feel that he had done his part ("You fulfilled your role as a patient, told a good episode").

Giordano, associating to Stafford's feelings, spoke of the closeness, the silence, and the desire that things seem above board on the bus ("Like when you run into someone in the john. . . , it might suggest some perversion or homosexuality"). He complained of his own inability to tell a story worthy of the group's attention.

Stafford then apologized for not being able to think of a useful question to ask Giordano about this problem, and Dr. Z directed Stafford's attention to feeling apologetic. Stafford talked about feeling apologetic in relation to concern with what others at the office might think when he was silent. Dr. Z suggested, "As you might feel you



have to apologize for the girl, so that others know at all times that your thoughts are clean, pure, and above board."

DISCUSSION: When Dr. Z found that Stafford evaded discussing what he presented ostensibly as a problem, his knowledge of the patient's psychodynamics enabled him to see that the patient's real purpose at the time was to gain the group's esteem for being able to talk about intimate matters and for putting on a good session before the observer.

By calling attention to the circumstances in which the anecdote was started, Dr. Z helped Stafford see that he was more concerned with the effect he was having on the group than with solving his ostensible problem. Instead of showing his usual evasiveness, Stafford then associated to episodes in which he had experienced similar feelings. This facilitated another patient's associations. The doctor's interpolations changed an obsessive monopolistic discussion into one with therapeutic potentialities for the monopolist and another patient.

The following account illustrates how a monopolist garnered new insight and became temporarily less monopolistic when the doctor directed attention to what he was doing in the group, in a setting of general irritation with him, after other techniques had failed.

### *Situation Analysis 10*

#### *DR. L'S GROUP, Meeting 2*

PRESENT: Bush, Charles, Throck (their second meeting)

Freedman, Hamling, Winston (their first meeting)

SETTING: Throck, a habitual monopolist with a tough manner, had described his deceased father as a bully; his mother as a coquette, who had considered the patient sickly and protected him throughout childhood. The parents had separated after many years of distrusting each other, and the patient said he loved neither. In his early years and at present he was almost completely isolated. He was intensely jealous of a deceased younger sister, who had made him feel "on the outside looking in." He felt that his psychoneurotic discharge from service carried the stigma of being "yellow," which he vehemently denied. The owner of a small shoe repair shop, he said that cobblers were an ignorant bunch but that he disliked working for anyone.

At Meeting 1 Throck had spoken compulsively and more than any of the others, for which he had apologized. No one acknowledged his apology. Dr. L had planned not to let Throck monopolize Meeting 2 and to this end had repeatedly called on other patients to speak. Throck, however, continually interrupted to talk about himself in an

unprofitable way. Dog-in-the-manger fashion, he could not use the focus to examine his own problems but attacked anyone else who tried to use the time to focus on himself.

As he was re-telling at length a story from a magazine, the doctor said, "Maybe you can tell us about your own problem." Throck then described his wife's family in some detail. When another patient questioned Throck interestedly about his anger at his sister-in-law, Throck replied that one of this patient's interpretations was possible but appeared rather evasive. As though irritated that Throck would not work on his problems, after this episode, other patients became somewhat hostile toward him. For example, when he asked Dr. L about a sweating palm and what it was called, another patient for the first time made a hostile remark to Throck and a third laughed and clapped his hands. Throck continued to advise or criticize the others for some time, but eventually changed his tactics to seeking sympathy rather than posing as less sick than the others and giving advice. He also commented that he had talked too much this week again and that next week he was going to "shut up" and see what happened. He then made a private reference to Dr. L about someone whom they both knew and went on with another long monologue. The doctor interrupted to ask another patient about his anger and anxiety. As soon as the latter started to speak, Throck questioned him about the disappearance of his headaches. He replied that Throck made things too simple. Throck said, "I am tying myself up in knots right now."

**EVENT:** The doctor then turned to Throck and asked whether he always got anxious when someone else was talking. Throck: "No, why?" Dr. L: "I've noticed that you feel a need to interrupt others."

**EFFECTS:** Throck replied: "No, my ideas just pop out." He said that he didn't mean to be rude. If he didn't get the words out immediately, his thoughts were gone. They wouldn't make sense later on. Dr. L asked whether Throck felt anxious if he didn't talk. Throck said, "No," but added that he made it a habit to talk to people—"You never know just who your customers may be." When he gave shoe shines, he engaged his customers in conversation because he could tell their attitude toward him by the tone of their voices. He reminisced about how in the service he always used to talk to stave off the others—"You never leave your back open to anyone in the M. P.'s." He told of a little girl who beat him up when he was four years old. That was the only time he had been beaten. As he talked his manner became less urgent, and finally he sat back relaxed, as though he were spent. The session ended.

Throck opened Meeting 3 by asking Dr. L for some papers about which they had spoken in individual therapy. He seemed only slightly less talkative than before. At the end of Meeting 4 Dr. L noted that Throck used fewer defenses and seemed rather subdued.

DISCUSSION: This habitual monopolist talked compulsively in situations with strangers in order to learn where they stood in relation to him and to control them. Neither ignoring him nor trying to focus on the content of his remarks had any effect. After the group had indicated their annoyance with him and he had made an unsuccessful change in tactics to hold his position in the center of the stage, he was able to express his discomfort. When the doctor focused on this, Throck became somewhat aware of the meaning of his behavior and less tense. The temporary success of the doctor's intervention seemed related to its occurring after the group and the monopolist had expressed their dissatisfaction or uneasiness.

It seemed to be particularly useful for the other members of the group to become involved in discussion of why they permit a monopolist to hold forth. This usually culminated in a group attack on the offending patient. In many instances such expressions of hostility seemed to be helpful to the monopolist, as in the situation analysis above. It is not entirely clear why this should have been so.

It may be, especially with the bullying type, that the monopolist's anxiety over his hostility and the damage it does (in reality or in his fantasy) in holding up therapy for all is relieved when somebody stands up to him. He is not so powerful as he feared he was. He is relieved in not being allowed to carry out his neurotic wish, with its attendant anxiety and guilt, and he can relax and find that he is actually more comfortable than when he kept the center of attention by his neurotic behavior. The attack by the other patients may also satisfy his masochistic needs; in monopolizing he is asking for punishment, and when he gets it he feels better.

In the following example, after many hours of fruitless examination of the content of the monopolist's talk, the doctor finally brought the patient up short by asking what had been accomplished, after the patient had himself expressed concern over the group's thoughts about him. This started a group attack on the patient which gave him a new insight.<sup>2</sup>

Allen, a habitual monopolist in Dr. R's Group 1, had both neurotic and schizophrenic characteristics. After he had been in the group for several months, he developed the habit of working in a rather set pattern, in which he would associate his past experiences with his present with the apparent intent of getting recognition and reward from Dr. R. The doctor worked with him on his need for approval, and his behavior in the group changed. He began to express himself more freely but also more diffusely. He would start on a topic and get lost in free association, which did not seem to relate to any of his problems. The other patients were acceptant and, with the help of Dr. R, would try to find out the significance of Allen's remarks. In the course of time they became somewhat critical of the repetitious character of the content, which no one seemed able to understand or analyze. More and more time in each meeting was being spent on this patient.

At the present meeting Allen said he would like to present a problem to the group. Contrary to their previous custom, neither Dr. R nor other patients in the group intervened as Allen rambled on for two hours about his sexual problems, sense of failure, and resentment toward his mother for not giving him love, and finally wound up with a highly destructive autistic fantasy about his mother, which he repeated with very little emotion. He then said, "Right now I feel that everybody in the group is against me. I must have bored you, since I have said all of this many times before. Bill looks as if he would like to land on me."

As Allen paused Dr. R asked him, in view of the fact that the same thoughts had been presented before, what had been accomplished. Before Allen could answer, Blake remarked, "We wouldn't mind listening to you if only you had something different to say once in a while." Sarcastically Terry added, "Haven't you had some other experiences besides the ones you describe here over and over again?" After a few moments of silence Allen replied, "Yes, I have had other experiences, but this is the first time I have ever held forth in a group like this. All I heard at home was to be quiet and listen, and here I have felt the same thing every time I have made my usual clumsy efforts to discuss myself. This afternoon I felt something inside me saying, 'Don't stop talking,' and I relentlessly went on, knowing how critical all of you would be." Then Dr. R and the others helped Allen to see that his present difficulties in the group were due to his talking solely to make them listen. This had been missed by Dr. R and the group in focusing on the verbal content.



Allen spent considerable time on this problem, both in individual and in group sessions, until his verbalizations became less significant as a means of dominating the group by making them listen and more significant for their content.

In the following account the doctor, by calling attention to the group's responsibility for permitting a habitual monopolist to hold forth, enabled the other patients to interrupt the monopoly and the monopolist to express a relevant feeling.

### *Situation Analysis 11*

#### **DR. N's GROUP II, Meeting 63**

**PRESENT:** Bly, Coombs, Castell, Ingram, and Veal

**SETTING:** The group was tense over the introduction of Coombs, a new member, about whom Bly had expressed resentment in Meeting 61.

The new member had had two years of individual and group therapy with Dr. N; the four old patients tended to relate primarily to the doctor, although there were many occasions in which they all discussed the same topic. They rarely examined their feelings toward one another, whereas in the group to which the new patient had formerly belonged, the patients examined freely their relationships to the doctor and one another.

Bly, the monopolist, an obsessive patient with acute anxiety, was an only son, admired and in later years deferred to by his family. However, he was terrified by memories of frequent beatings from his physically powerful father, distrusted his mother for "betraying" him to his father, and feared his maternal grandmother, the family matriarch. He felt insignificant and helpless but secretly powerful through his superior intellect and verbal ability. He accused the doctor of trying to dominate him and constantly asserted his independence, while acting like a dependent child. He had murderous fantasies concerning the doctor. He tried to solve this conflict by trying to baffle the doctor with obscure material, thereby secretly maintaining control. By monopolizing the group he kept the doctor exclusively for himself. He was very adept at spuriously associating to others' material, in order to get himself back in the center of attention. He had been helped to examine his maneuvers in many previous meetings, and he had frequently been able to analyze the situations which provoked his anxiety.

Bly had monopolized much of Meeting 62, as described in Situation Analysis 34. In Meeting 63 he was again the first member to speak;

he rambled on for about half an hour, as the doctor alternately tried to question, interpret, or reflect the material he was presenting.

EVENT: When Bly paused briefly, the doctor asked, "I wonder why the group lets Mr. Bly do all the talking today?" Bly answered quickly, "I do too—I was so wrapped up in myself I just went on and on." The doctor did not answer Bly but spoke again to the group, "What about Mr. Bly? His feeling seems to be that he is the only one who counts and that the rest of you are just little children and don't count at all." Bly said defensively, "Well, if somebody else had been talking, I wouldn't talk at all. I asked when I first came in here if anything else was going on."

EFFECTS: Coombs said that Bly had seemed like a little child who knew no one was paying him any attention. All the patients but Ingram said in effect that they felt cut out, that Bly had behaved in a childish fashion, and that they were annoyed by it. Bly admitted that he certainly did feel even younger than before he went into the service. He was annoyed at himself for letting the group see that he felt childish and felt that the group was justified in ganging up on him. Coombs assured Bly that it was not his fault—that the group members could have kept him out themselves, if they had wanted to; he pointed out that they themselves were too weak and needed help from the doctor. The doctor stated that Bly tried to conquer his feelings of insignificance by getting into the limelight but acted them out by behaving in a childish fashion.

TENTATIVE DEDUCTION: Thus the doctor temporarily resolved a situation with a habitual monopolist when he called attention to the group's responsibility for what was going on.

### SUMMARY AND IMPLICATIONS FOR THERAPY

In short, the problem of dealing with the habitual monopolist is that the group setting itself stimulates behavior which impedes therapeutic work. At times the doctor feels in the predicament of being unable to treat the patient until the latter recovers from his symptoms—in this case, compulsive monopolizing. Whether such patients can be treated in groups such as ours and if so, how, remains to be studied further.

It may be that habitual monopolists should be excluded from groups until the problem is worked through in individual sessions. It is therefore important for the doctor to recognize the monopolistic pat-

tern early in treatment. In view of the small size of our series and the inexperience of many of our psychiatrists, a pessimistic conclusion is not yet warranted, especially as at times certain techniques were temporarily successful in creating a more therapeutic situation. However, habitual monopoly would seem to be a contraindication to keeping a patient in the group of an inexperienced doctor.

We found that common techniques such as reflecting the patient's remarks back to him, ignoring or rebuffing him, and questioning him about his monopolizing were useless. The common feature of successful techniques was that they made the patient aware of the meaning of his behavior with respect to his relations to the group at the time. It seemed helpful under different circumstances to hold the patient to a detailed examination of a single situation in his daily life that was relevant to the group situation, to examine with him his feeling about the immediate group situation at the point when he started to monopolize, and to call attention to the development of dissatisfaction on the part of the group and of the monopolist with this behavior. It also proved important to call the group's attention to its share in the responsibility for the continuance of the monopoly.

## CHAPTER VIII

### *Resolving Tension through Rallying Topics*

---

THE situation analyses in this chapter illustrate how a group, when insecure and resistant to therapy, may seek mutual support by finding a topic around which most or all of its members can rally. This relieves tension sufficiently for therapy to progress. The rallying topic may be either personal or impersonal but must have implications for all or most of the group. In short, it is chosen by the patients rather than the doctor; the topic itself is in focus, rather than any one patient; more than two patients contribute to the discussion, which is sustained; it is related to temporary release of tension and submergence of rivalry and anxiety.

In the following situation analysis of a meeting at which doctor and patients seemed to be at cross-purposes the tension was resolved by a series of rallying topics, followed by increased intimacy of discussion and focus on one patient.

#### *Situation Analysis 12*

##### **DR. N's GROUP III, Meeting 3**

**PRESENT:** Bridges, Cann, Goodfriend, Minor, and Small

**SETTING:** The group had been quite self-revealing in the latter half of the first meeting, and in the second meeting had begun to look to the doctor for answers without getting them. Early in the third session Goodfriend asked Dr. N about the meaning of not stepping on a line. The doctor said that this was "something to talk about." Then Cann and Goodfriend reminisced about childhood tensions, and Dr. N asked Goodfriend, "Do you bring these things up because they bother you now?" Goodfriend said that he had been concerned about them as a kid. Small told Goodfriend that as a kid he, too, had played the game of avoiding lines, and Cann mentioned walking a picket fence.



Cann and Bridges then asked Dr. N about the effects of a jittery world on the development of neuroses. The doctor observed, "The group seems to be trying to make me into an oracle today," adding that everybody had started by asking questions. Dr. N: "I wonder what that means." Bridges: "I'm not sure what we're supposed to do. . . ."

A few minutes later Bridges asked, "What's in a dream?" Dr. N focused with Bridges on the content of his dream for a few minutes, after which Bridges asked, "Well, what is a nightmare?" At this point Dr. N observed that what had gone on was first a series of questions directed to the doctor, then his calling attention to them, then general conversation, and then questions directed to the doctor again. Small said that he had reconsidered what had happened at the last meeting and thought that they all had trouble with responsibility, some too much of it, and some not enough. Goodfriend and Cann approved of Small's observation.

After Cann had brought up two dreams he had had and Dr. N had briefly discussed them with him, ending by saying, "You have a very resourceful mind and it's quite possible you can work that out," Goodfriend started to ask the doctor questions about whether human beings are basically lazy. Dr. N said that he wondered why Goodfriend asked the question.

**PRECIPITATING EVENT:** There was a knocking in the room downstairs, and Bridges said the noise brought back to his memory that he did dream of the war years and artillery fire—"Now, why should that be?" Dr. N asked Bridges what kind of answer he expected. Bridges said that he wondered why he should dream that and wake up crying and then asked, "Should we be thinking of those things now?" Dr. N replied that Mr. Bridges had probably had some bad experiences in the war.

**EVENTS:** The patients rallied, first around war experiences, then around more intimate concerns about the absence of feelings at the death of a significant person, then around the topic of neuroses and feelings of difference.

1. Bridges said that his war experiences had been no worse than anyone else's. Cann immediately explained that the mind works by association and gave an example of being bothered by the backfiring of cars after the war, as well as other examples from his class at college in abnormal psychology. Small said that he had had trouble getting a driver's license because backfiring and the noise of a siren had sent him scrambling into cover in a ditch, leaving his car to ride unchauffeured into a building. Cann said that in

the front lines they had lived by perception alone. "Our lives depended on it. We just go on under those reactions at home." Bridges said that he had never thought of all this until now. Cann said he had sometimes worried at home about planes headed for an airport.

2. After Cann had led a brief digression on generalities about culture and the doctor had brought the group back to the present, Bridges wondered why it was that he felt upset when someone was sick but had no feeling when someone died. It upset him, he said, to have had no feeling at his grandfather's death. Dr. N reflected, "No feeling?" and Bridges told of how sickness upset him but not death and of his lack of feeling about the recent death of a vice-president of his concern with whom he had a good relationship. Dr. N suggested that this might make him feel different from others. Bridges then told of the first dead men he had seen in combat, and asked whether his reactions showed "a cold heart." Then Small contributed to this topic by telling how he had felt nothing at the death of a very close friend's mother, although he had given the codeine shots she needed to ease her pains. Cann then told of discussing with a sociologist his own absence of feeling at the death of his father. Bridges told of a discussion he had had with friends in which they claimed that if Bridges suddenly lost his father and mother he would have no feelings for a year. He asked, "Now what do they base that on? Are there similar cases?" Dr. N replied that having no feeling is a way of protecting yourself.
  3. After an intervention by Goodfriend, Bridges asked, "What is a neurosis?" He described a girl co-worker whose stomach trouble was diagnosed as neurosis. Dr. N assured him that a neurosis is "not imaginary, it's perfectly real." Cann mentioned his diarrhea as an example of its reality, and Goodfriend asked whether everybody doesn't have "stresses." Dr. N said that there are no sharp differences between neurotics and other people. They have to look into their lives for their trouble—"That's what neurotic means to me."
- Bridges then loudly objected to the loose way in which gangsters and others are called neurotic by the newspapers. Cann disparagingly mentioned a fellow who wore a pink suit all his life and was suddenly called neurotic for it. Small said that most of the soldiers who received medical discharges from the army were nervous fatigue cases. Bridges said that he felt like punching in the nose anyone who used the word "neurotic" to him. He said that he had resented his family's attitude toward him when he returned from overseas—they had wanted him to rest. The proper word for him,

he said, was "touchy." Cann said that the word "neurotic" had different meanings. Goodfriend said that so many people fall under this term today that he didn't think he was touchy any longer.

**EFFECTS:** After a brief discussion between Dr. N and Bridges, Minor observed that Bridges didn't wait for the doctor's answers but asked questions just to show that he knew the answers. Bridges accepted this interpretation. Minor then focused on the change that had come over him, on how much worse he had grown, on how seemingly irresponsible he had become. He continued practically until the end of the meeting. Dr. N and the other patients focused with Minor on this.

**DISCUSSION:** The doctor's focusing on process with an implied rebuff at the outset of this meeting, when Goodfriend and Bridges had personal questions for him, seems to have driven the patients to seek support from one another. Moreover, self-revelation had been quite extensive during Meetings 1 and 2 of this group; there may well have been developing a certain amount of hostility toward the doctor because he had given no panaceas.

The doctor's first responses to the patients' questions had implied a rebuffing attitude; he then changed to a more acceptant one by indicating interest in their dreams; and soon afterward the patients found an emotionally significant topic around which they could rally. The discussion continued in this pattern for much of the rest of the meeting. The doctor's change in attitude may have facilitated the rally, although direct evidence for this is lacking (see Table 8).

The first rally was followed by one patient's telling more about himself than he ever had before, and at the end of the meeting the immediate personal problems of another patient became the focus of a comfortable discussion. This focusing on one patient, so often seen after a rally, may be related to the reduction in tension brought about by the rally.\*

**TENTATIVE DEDUCTION:** When patients felt tense over being rebuffed by the doctor, they resolved the tension by rallying around a series of emotionally significant topics, increasingly relevant to the situation of Meeting 3.

Situation Analysis 13 shows how, in a meeting in which the patients were tense and critical of one another, agreement was first reached on a point of self-criticism. They then rallied on criticism of parents, after which they were self-revelatory.

\*See p. 145.

*Situation Analysis 13**Dr. P's GROUP I, Meeting 2*

**PRESENT:** Incliffe, Merrick, Kapp, and Cook (all except Cook present for the second time)

**SETTING:** The group consisted of Merrick, an exhibitionistic patient who spoke with facility; Kapp, who feared he might be held in contempt if he revealed his illegitimate birth; Incliffe, a pedantic former graduate student who refused to accept responsibility; and Cook, an excitable new patient who talked at length with bravado. During the first meeting and half of the second, the patients talked on a variety of topics without focusing on personal problems. Tension developed as each tried competitively to show superiority. The doctor did not attempt to put them at ease or to offer support.\*

The present meeting started with a continuation of the struggle for status. Incliffe said that he felt there would be less squawking about the economic system if people would knuckle down to getting ahead economically; Kapp said that he was pretty disgusted with millionaires. Merrick, responding to a reference to the fact that two of the other patients had gone to college, said, "Some people with Masters' Degrees don't know what to do." Cook talked a great deal in a manner that seemed to forestall inquiry. He advised Merrick to take V.A. Placement Tests; told about his own success at working a hobby up into a money-making proposition. Then he wandered on to lecture the group about the value of self-confidence.

The group became tense while the patients criticized one another for dealing with superficial rather than underlying personal problems. The consensus was that the group feared to forge ahead. Incliffe rejected Cook's recommendations as "Readers' Digest psychology" and started a discussion of ways of escaping.

**PRECIPITATING EVENT:** Incliffe observed that if things were right at home "there would be no need to escape."

**EVENT:** Merrick facetiously said that the great problem is to have the "right woman at home," and Cook scolded him about this, concluding, "Solve your own problem and the woman may not be the wrong one after all." Enthusiasm and some spirit of comradeship appeared as soon as Incliffe proposed that the "system," not they, was at fault. Cook blamed the puritanical code for his lack of experience with sex prior to his marriage. Parents who inflict a puritanical code on their children were made the scapegoats. All agreed that it was futile to try to re-educate parents.

\*For an account of the first meeting of this group, see pp. 121 f.



**EFFECTS:** The group relaxed and the members promptly brought up personal problems. Cook, who had previously been lecturing the others, asked the group to help him in a decision about whether to be an usher at his brother's wedding, when he had expected to be best man. All urged him to go because his chagrin seemed irrational. Cook referred to this again in Meeting 4—"You guys really gave me food for thought."

Incliffe, as the meeting ended, gave up his insistence on intellectual and "will power" solutions and asked the group's advice on how to get along with girls.

After the meeting Kapp detained the other three patients to tell them about his shame over his illegitimate birth; he later reported to Dr. P his sense of comfort when they did not seem to be contemptuous. He reviewed the facts again at the next meeting and participated more actively.

**DISCUSSION:** It would appear that in this situation, in which the doctor was non-supporting and the patients were tense and mutually critical, the tension was relieved when the patients found a topic upon which they could all project their hostility. The patient who introduced the topic was one who habitually tried to blame others. In this situation his attitude was useful to the group. The rally may have made it possible to proceed to helpful discussion of personal problems. An immediate impetus to the rally may have been the patients' agreement that they were afraid to forge ahead.

Situation Analysis 14 shows how an experienced group overcame its block by rallying around the topic of why the members were silent.

### *Situation Analysis 14*

#### **Dr. N's GROUP I, Meeting 65**

**PRESENT:** Coombs, Eubank, Gugis, Milton, and Trippitt

**SETTING:** The attitude of the patients toward the doctor and one another was largely negative, although there had been little verbalization of this. Milton had been very resistive to therapy for the last two months, constantly reverting to the fact that Dr. N had made him angry by misinterpreting what he had said on one occasion. Eubank was usually silent in the group, and his attitudes toward it had not appeared. In a recent individual interview he had said that he was angry at the group. Trippitt's attitude was primarily positive, but in the meeting preceding this one he had indicated disappointment with his progress. Coombs' attitude toward Dr. N was compliant, but he

had shown hostility to the group, especially to Trippitt. Gugis had indirectly expressed negative feelings toward Dr. N.

The patients were accustomed to expressing hostility toward one another by asking probing questions. The habit of self-examination was well established. This meeting began with Milton's expressing his sensitivity to the sign "Mental Hygiene Clinic." When the group failed to support him in this feeling, he withdrew. Trippitt broke the silence which ensued on Milton's withdrawal to ask whether anyone had had heart pains since the death of Weber, who had suffered a heart attack two months earlier, soon after being discharged from psychiatric treatment. (There had been only a brief discussion of feelings about it in Meetings 59 and 60, while the regular psychiatrist was on vacation.) Dr. N ended the discussion which followed by questioning whether it would be profitable to continue. (He stated to the observer after the meeting that he might have been unknowingly sensitive to Weber's death.) This was followed by a tense and awkward silence.

Dr. N tried to deal with the situation by asking if anyone wanted to discuss anything from individual interviews. There was another long silence, all the patients seeming self-absorbed. Trippitt tried to shift the focus to Coombs by commenting on his appearing engrossed. Coombs said that he was "just sitting."

PRECIPITATING EVENT: Gugis, with a malicious smile, said that he had been waiting to see whether Trippitt or Milton would speak first. He said that it was characteristic of Trippitt that he couldn't bear an awkward situation, whereas he, Gugis, did not mind it. Gugis then asked if this actually was an awkward situation, saying that he and others didn't feel it as such.

EVENT: There followed a discussion of how various patients reacted to a silence in the group. Trippitt stated defensively that in breaking the silence he took his cue from the doctor. Dr. N asked what was awkward about silences, and Trippitt said that he talked in order to "maintain himself." Milton spoke to Dr. N about his inability to stand a silence, and Dr. N interpreted this in terms of Milton's anxiety about what people might be thinking of him. Milton said that he had also found the silence awkward. Gugis tried repeatedly and unsuccessfully to shift the discussion to Trippitt's not "giving anything to the group" when he talked. Trippitt suggested that others had problems too. There followed an acrimonious discussion punctuated by silences, in one of which Gugis commented that everyone was so "damned silent" and Milton remarked again that he was uneasy. Coombs

brought the discussion back to patients' feelings in the group, saying that Trippitt always thought that he did all the talking and Coombs thought that he (Coombs) did the talking.

**EFFECTS:** There was tension-relieving laughter as Gugis remarked that whenever he talked he felt as if he had been tricked into it. Eubank said he felt "caught all the time" and was afraid that, because he smiled while talking, others would think his problems were not important. This led to a fairly extended discussion of his feelings.

Trippitt talked about his problem of loving his girl, and in a friendly way he and Gugis together analyzed how their attitudes toward girls were related to their sense of inferiority. The meeting concluded with Trippitt asking Gugis how he knew his relatives didn't like him and Gugis saying that he gave them "no incentive." Trippitt asked why Gugis had to give them an incentive, and Gugis responded, "That sounds like Trippitt's problem." Trippitt: "It is!" Gugis: "Mine too!" Laughter over this ended the meeting.

**DISCUSSION:** An uncomfortable silence arose when the doctor terminated the discussion of patients' feelings about the death of a former patient. This topic had been introduced in an atmosphere of negative feelings carried over from previous meetings and may have been an indirect expression of hostility toward the doctor. Gugis took the lead in trying to break the silence, by calling attention to it. He was the patient whose negative feelings about Dr. N seemed closest to direct expression. In calling attention to the silence he seemed to be pointing out the hostility of others to the doctor.

It appears that in rallying around examination of their feelings about silences, the patients displaced resistance from the doctor to the group. That is, they talked as though their feelings about breaking a silence were related to their feelings about one another, rather than, as seemed to be true in this case, to their feelings about the doctor. The tension was released, as signalized by laughter, when they shifted from feelings about silences (i.e., resistance to therapy) to feelings about talking (i.e., acceptance of therapy). The active intervention of the doctor was slight and did not affect the course of the discussion. Only after everyone had participated in this release of tension could the patients participate in collaborative discussion of personal problems—indicating that their resistance had been worked through.

**TENTATIVE DEDUCTION:** From this situation it appears that when the patients of an experienced group are blocked by hostility toward one another and the doctor, the patient most easily able to express hostility may lead the others to rally around a discussion of their present

behavior, with resulting relaxation of tension and return to consideration of personal problems.

Table 8 summarizes common factors of rallying topics which were successful in relieving tension and facilitating movement of the group. It includes data from material presented elsewhere in the book as well as the situation analyses of this chapter.

### SUMMARY AND IMPLICATIONS FOR THERAPY

The seven situation analyses summarized in Table 8 present a similar dynamic pattern. In one way or another each group had reached a therapeutic impasse. In Situation Analyses A and 2\* the impasse may have been brought about by the doctor's silence, in Situation Analysis 13 by his non-supporting attitude, and in Situation Analyses 12 and 14 by his rebuffs. We may, therefore, conclude that in these situations, the basic characteristic of the doctor's behavior was lack of support sufficient to the group's needs. In Situation Analysis 34† he was insensitive to the patients' feelings about the introduction of a new member.

The topics under discussion during the impasse did not seem to be important—the only significant factor seems to be that the group became tense because the therapeutic interaction was blocked. The tension was variously expressed—by silence, shuffling about, uneasy glances, or inappropriate laughter or remarks.

In several of the less experienced groups the fear or shame involved in talking about intimate affairs before strangers came into conflict with the understanding that this was essential to therapy (Situation Analyses A, 12, and 13), as well as with the wish to please the doctor by doing what he expected (Situation Analysis 2). In the experienced groups (Situation Analyses 14 and 34), although the patients were able to talk more intimately about themselves, a crisis had occurred with which the doctor had seemed unable or unwilling to deal. In each case an intensely uncomfortable situation had developed.

\*See Chapter v. Situation Analysis A is based on the account given on pp. 123 f. Situation Analysis 2 appears on pp. 125-129.

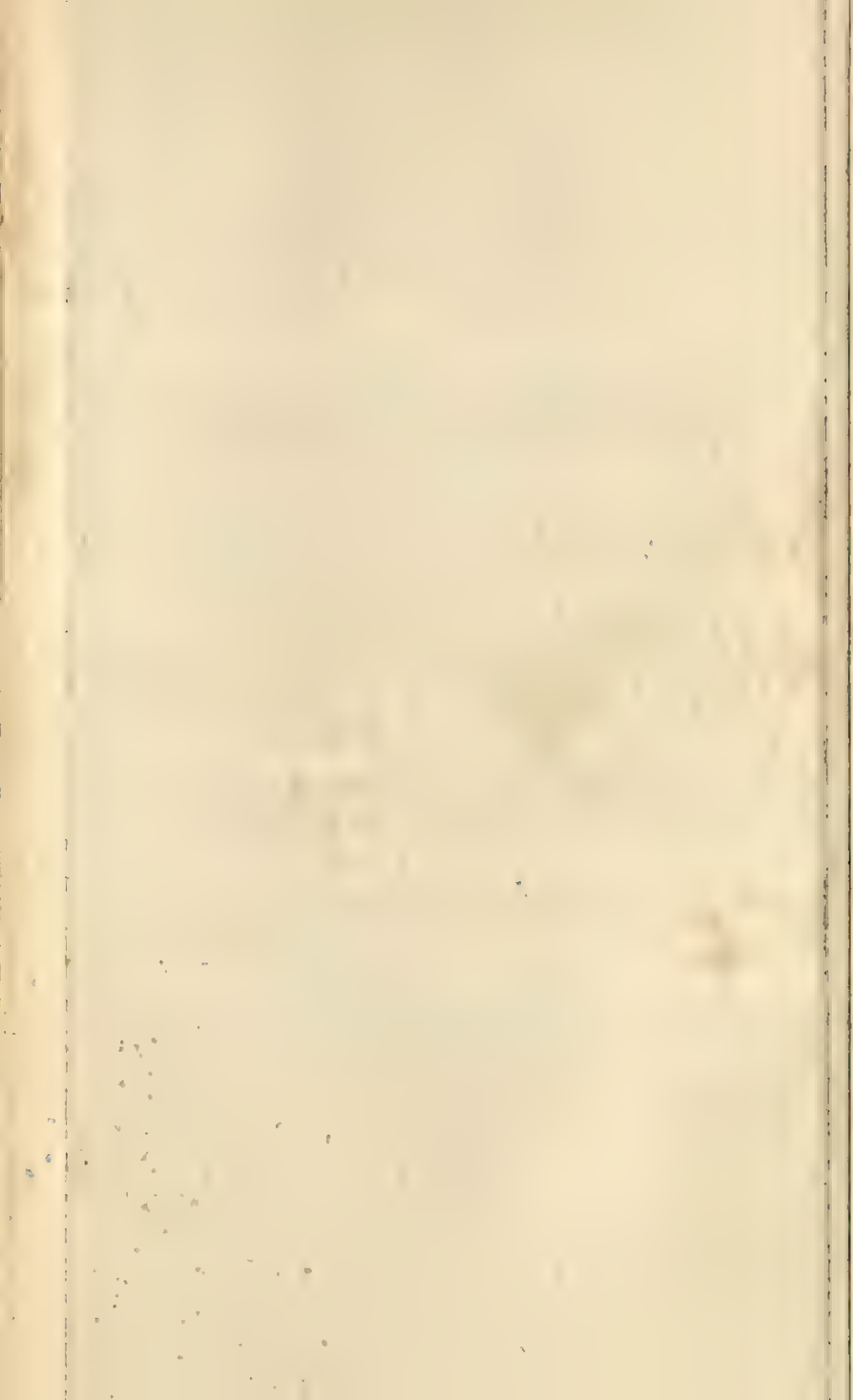
†See Chapter xii.

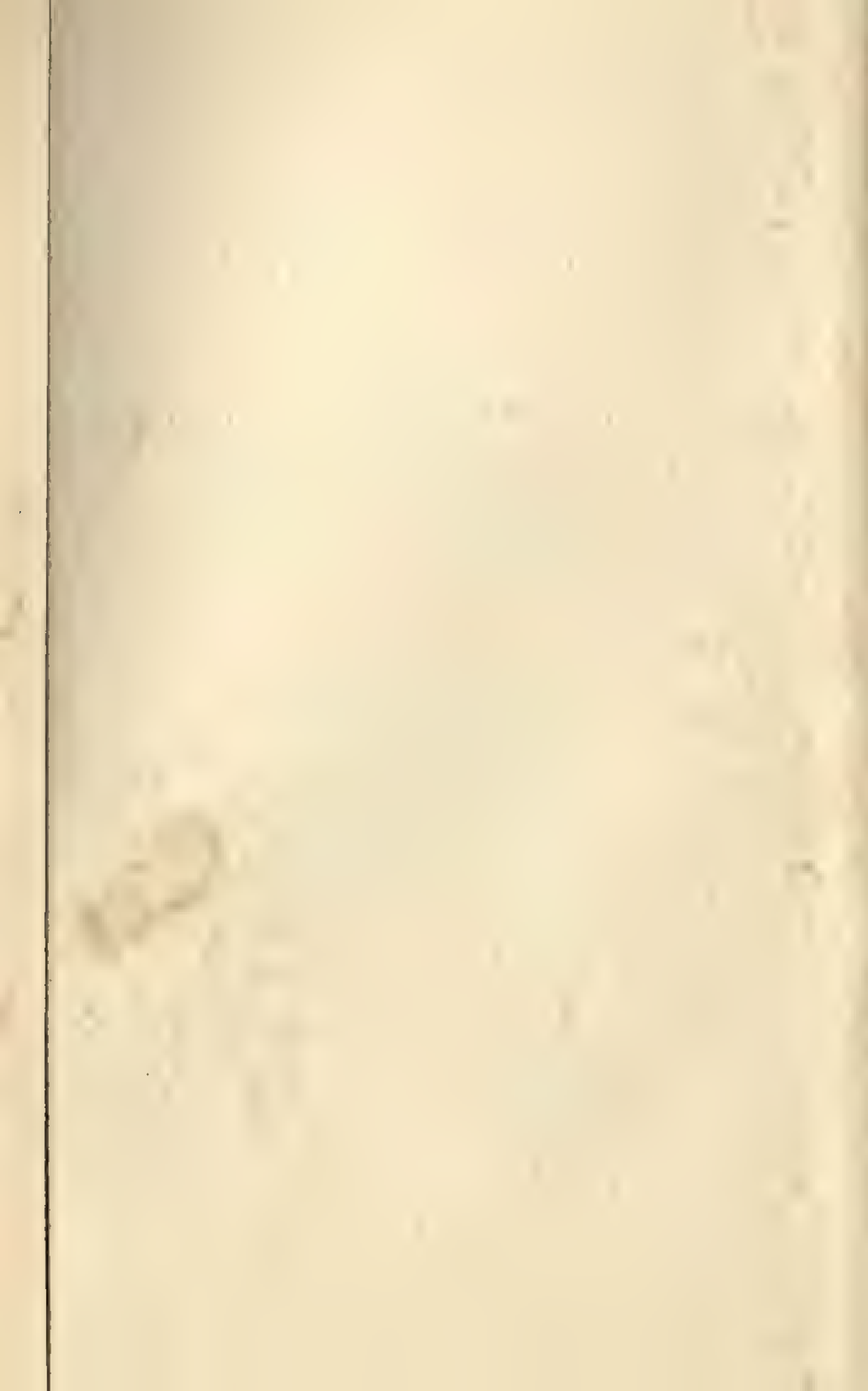


Rallies were facilitated when the doctor called attention to the conflict without putting pressure on the patients for a response (Situation Analyses A and 2) or went along when a patient brought up a subject relevant to the conflict (Situation Analyses 12, 13, 14, 34, and B<sup>\*</sup>). The patient who introduced the topic around which the members rallied was usually one who talked easily. In neither of the two experienced groups did the patients wait for a comment from the doctor, as they had in some of the earlier ones. This was consistent with the greater self-reliance of mature groups. In most cases the topic was relevant to the conflict, although the relevance might not be immediately apparent. For example, when the patients talked about disliking to come to a place plainly marked "Mental Hygiene Clinic" (see Situation Analysis 34) they were indirectly expressing their feeling that they were not being helped.

A rallying topic *per se* is not necessarily therapeutic. Our experience indicates that the group must have a sense of direction and feel some pressure in the direction of getting down to business; otherwise a series of rallying topics may simply reduce the tension to the point of complete apathy. The doctor must indicate his awareness of the group's difficulty in an uncritical way. It is important that he overcome any feeling of anxiety he may have about the group's silence or the non-therapeutic direction of the discussion. His attitude must be one of interest and confidence, and he must communicate this to the patients.

<sup>\*</sup>See Appendix A, which includes the Running Account on which Situation Analysis B was based.





## CHAPTER IX

### *Hostility toward the Doctor*

---

AN important goal of group as well as individual therapy is to help patients bring to light and analyze their hostility and its effect on their behavior and satisfactions. Originally directed against the patients' immediate families, this emotion may be transferred in the course of treatment to the doctor or to other members of the group. It is sometimes evoked by the patients' stereotypes of the doctor and sometimes by the doctor's own attitude or behavior.

In our experience two common stereotypes which created conflicts concerning the doctor were that he was a person apart and that he had the power to cure patients if only he would. The belief that the doctor belonged to a special order of beings, although it might be reassuring to some patients for a while, inevitably led to hostility, whether brought out or not, when the doctor did not live up to the picture. Also, it sometimes made a patient feel that the doctor could not understand him, as the doctor was so different. For example, the patients in one group discussed the subject of whether the doctor had personal problems. One patient said that he didn't want the doctor to have any; two patients said that they thought the doctor would be more understanding if he had problems like other people. In another group, a patient said that although a psychiatrist was smarter than the average person, he lived in his own little world. He might have grown up as other fellows did, but had long outgrown his childhood. ("He wouldn't know as much about the average guy. It is good to have things come from other guys in the group.") A schizoid patient said to the doctor, "It seems to me that you can never be on the same level as we are. You have never been through these problems. It seems that you are smirking. These things seem such a trifle to you.



You think that anyone could overcome difficulties like ours with common sense. You are paying no attention to what's being said."

The most disturbing feelings, however, seemed to center on the doctor as the person who knew what was wrong with the patients and could cure them if he wanted to. Some patients tended to vacillate between thinking that he had this knowledge and power and was perversely refusing to use it, which made them angry, or that he really didn't know the answers, which was frightening. If he did have the power to cure them, then it was important to stay in his good graces, so that anger must be concealed. If he didn't have such power, then one must be careful to maintain the fiction that he had it by not doing anything that would show up his lack of omnipotence and so give reality to the fears.

Stern, a patient in Dr. P's Group 1, indicated to a substitute psychiatrist considerable ambivalence toward Dr. P. His doubts as to Dr. P's competence conflicted with dependence on him for help and need to keep his respect. In addition, this patient felt that Dr. P would lose respect for him and withhold help if he revealed "shameful" material to him.\*

At one point Rothschild said to Dr. K, "Suppose I showed hostility. Suppose you didn't know how to handle it. You're sort of the ace of spades." Hammond: "I don't see the point." Dr. K then turned to Rothschild: "Is it possible that you couldn't control your anger? And if I couldn't, wouldn't that be terrible?" Turner: "Are you afraid the doctor might lose prestige?" Rothschild: "Yeah, if he lost, where would we all be?"

Trippitt described some of his conflicting feelings about Dr. N's knowledge and power. If he defeated the doctor, he said, he increased his own status with the group. He felt that he needed to be able to explain everything himself and to understand all his hidden springs, but he pictured the doctor as omniscient. When Dr. N asked if this meant that the doctor knew the answers but wasn't telling Trippitt, the latter answered, "You're not telling me because you're not certain." He added that he wanted the doctor to be omnipotent and omniscient. "It may feel good to be able to compete, but it doesn't leave me in a good frame of mind." Later Trippitt said that he was sure that the doctor knew all the patients' defects but was waiting for them to make the discovery themselves and be cured. Dr. N asked what this meant

\*Cf. Stern's behavior in Chapter v, pp. 133 f.

to Trippitt, who replied, "It's putting the responsibility on me. You know how these things work out because of your experience. . . ." Within the space of a few minutes this patient thus described his conflicting stereotypes of the doctor and how they created conflict in him. He combined deference for Dr. N with resentment and competition.

The following situation analyses indicate how the presence or absence of support from the group and the doctor, and their methods of giving it, are related to a therapeutic outcome from a display of hostility to the doctor. In Situation Analyses 15, 18, 19, 20, 21, and 22, we see that support from the group and easy acceptance by the doctor enabled patients to express hostility and thus to gain new insight. Conversely, in Situation Analyses 16, 17, and 23, patients attempting to express hostility were blocked by the opposition of the group and the inability of the doctor to accept their hostility. The first four situation analyses (15 through 18) are taken from the experiences of one doctor, who was highly sensitive to patients' hostility to him and made great efforts to change his attitude in this respect so that he could treat patients more effectively. In the first example hostility was not overt until he brought it out. He then dealt with it successfully. In the second and third, perhaps because of the presence of an extremely angry patient, he was unsuccessful. In the fourth example, illustrating a much later stage in the group's history, this patient was absent and the doctor's ability to deal with this problem had improved.

In Situation Analysis 15, when the doctor was insecure, patients protected him; when he became secure, he was able to elicit expressions of anger at himself and bring out their transference aspects.

### *Situation Analysis 15*

#### *Dr. K's Group, Meeting 12*

**PRESENT:** Turner, West, Steele, Hammond, Mercer, and Trill

**SETTING:** The doctor was deeply interested in his patients and eager to help them but was somewhat constricted and intellectual. He had said very little in the group up to Meeting 10. He reported that this was probably the result of his doubts about group therapy and his fear of his own urge to dominate the meetings. His interventions had generally been prefaced by an apology—for example, "I don't want to interrupt you men, but. . . ." The patients had developed habitual

ways of relating to one another and some unspoken ground rules which included a protecting attitude toward Dr. K. By Meeting 10, the doctor had worked through with himself much of his hesitancy to assume responsibility and could comfortably invite expression of doubts about himself. Patients first responded by verbalizing their protective attitude. Steele: "I think Dr. K is feeling his way; he hasn't had years of experience. . . . He has a hard time in one hour a week getting to know a hundred patients. . . ." Turner objected to note-taking in individual sessions, then agreed that Dr. K had "no time." Steele: "If he's only going to be with us one day a week he needs his notes."

The patients went on to express resentment of having had to put up a front for parents' inadequacies. Steele told of having felt not wanted, of memories of neighbors bringing his drunken father in off the sidewalk, of days when there was no food in the house, and of keeping up the pretense of theirs being a worthy old family. Dr. K: "I wonder if this shame of his father is one of Steele's unique experiences." Steele: "Shame and fear—I hate to shame him." The group was silent. Then Turner told how he despised his father's evasion of providing a home by renting expensive hotel apartments. Dr. K: "I wonder if it's weakness in our fathers that we don't like." Hammond responded by expressing the embarrassment he felt for his father when his mother complained at the breakfast table of lack of money and his dislike of having to make his father feel that he was not a failure. He was ashamed to be seen in public with his father, "painfully conscious of failure and trying not to notice." Trill objected, "I can see my grandfather's weaknesses. You say you can't stand to look at your father's weaknesses. Why?" Dr. K: "I wonder if we could understand by reflecting that the ideal father should be a model for us to pattern after. Then what happens when he sort of lets us down? We like to think of ourselves as chips off the old block, and if the old block is an unadmirable one, why, what does that make us?"

The doctor's change from passive to active participation was further reflected in the patients' behavior in Meeting 11. West, who had participated very little, announced that his problem was an unnatural sex drive and in the first few minutes all present reported concern over their passive fantasies concerning sexual relations. When Dr. K pointed out that they might be demanding too much aggressiveness of themselves, all were able to tell of having been worried because at times they had preferred the position of being on their backs in intercourse.

EVENT: Since Dr. K's change from passivity to activity had been

marked by such a change in group behavior, he decided to promote expression of their previous hesitancy to share these fears of passivity. Early in Meeting 12 he said, "I wonder if there isn't a lot in the relationship you fellows have with me that resembles some of the difficulties you talk of with parents and others in the past; if you aren't similarly holding back."

EFFECTS: At first, expressions of resentment against Dr. N were forced or self-punitive. Hammond said it would be bad taste for him "to sound off against the doctor." Turner, protesting confusion, said his complaints had taken the form of telling himself that the doctor was incompetent. ("It's like a dependent boy saying mamma isn't doing *everything*.") West asked for drugs to facilitate expression of his feelings. Steele said that his previous doctor had been an older man. Trill: "My resentment of K has been slight." Dr. K observed that small resentments, if not expressed, can get so big that they can't be expressed. Turner then went on openly to speak of resentment of the doctor's type of leadership: "I felt that I got it in the neck when I did bring out my feelings to Dr. K." He said he had felt that the doctor was sadistic toward him, that most of the doctor's suggestions were strictly textbook suggestions, and that he did not like to be treated as an average man with an average background. When another patient said that he too had been blocked in free association, Turner repeated, "I try to appease the mad beast over here with tidbits" (referring to Dr. K). The meeting concluded with Hammond, Mercer, and West complaining that they had been unable to lay problems before their parents as children.

In Meeting 13 the patients spontaneously brought up the topic again. Dr. K replied, "I think it would be useful to express these feelings about me." Trill, who had previously been the most blocked, at first said that his antagonism was based on wanting the doctor to take a more active part. "Another thing I resent; he's always so God-damn ready to back down instead of taking a stand. . . . It's the way he's so humble—like a Jap—'so solly'—when you kick him in the teeth. Am I being clear?" Trill went on to say that he was similarly irritated with his wife because she seemed to have no plan. Then he complained about the passivity of a girl friend. Turner: "If she asked to do something with you, it would raise your self-esteem—just as if Dr. K would take a stronger lead with me I'd feel, O boy! he thinks something of me." In later meetings expressions of resentment were more often associated with new insights and less often merely complaints.

DISCUSSION: The situation analysis seems clearly to demonstrate how hostility may be directed against the doctor because of a resemblance



ways of relating to one another and some unspoken ground rules which included a protecting attitude toward Dr. K. By Meeting 10, the doctor had worked through with himself much of his hesitancy to assume responsibility and could comfortably invite expression of doubts about himself. Patients first responded by verbalizing their protective attitude. Steele: "I think Dr. K is feeling his way; he hasn't had years of experience. . . . He has a hard time in one hour a week getting to know a hundred patients. . . ." Turner objected to note-taking in individual sessions, then agreed that Dr. K had "no time." Steele: "If he's only going to be with us one day a week he needs his notes."

The patients went on to express resentment of having had to put up a front for parents' inadequacies. Steele told of having felt not wanted, of memories of neighbors bringing his drunken father in off the sidewalk, of days when there was no food in the house, and of keeping up the pretense of theirs being a worthy old family. Dr. K: "I wonder if this shame of his father is one of Steele's unique experiences." Steele: "Shame and fear—I hate to shame him." The group was silent. Then Turner told how he despised his father's evasion of providing a home by renting expensive hotel apartments. Dr. K: "I wonder if it's weakness in our fathers that we don't like." Hammond responded by expressing the embarrassment he felt for his father when his mother complained at the breakfast table of lack of money and his dislike of having to make his father feel that he was not a failure. He was ashamed to be seen in public with his father, "painfully conscious of failure and trying not to notice." Trill objected, "I can see my grandfather's weaknesses. You say you can't stand to look at your father's weaknesses. Why?" Dr. K: "I wonder if we could understand by reflecting that the ideal father should be a model for us to pattern after. Then what happens when he sort of lets us down? We like to think of ourselves as chips off the old block, and if the old block is an unadmirable one, why, what does that make us?"

The doctor's change from passive to active participation was further reflected in the patients' behavior in Meeting 11. West, who had participated very little, announced that his problem was an unnatural sex drive and in the first few minutes all present reported concern over their passive fantasies concerning sexual relations. When Dr. K pointed out that they might be demanding too much aggressiveness of themselves, all were able to tell of having been worried because at times they had preferred the position of being on their backs in intercourse.

EVENT: Since Dr. K's change from passivity to activity had been

marked by such a change in group behavior, he decided to promote expression of their previous hesitancy to share these fears of passivity. Early in Meeting 12 he said, "I wonder if there isn't a lot in the relationship you fellows have with me that resembles some of the difficulties you talk of with parents and others in the past; if you aren't similarly holding back."

EFFECTS: At first, expressions of resentment against Dr. N were forced or self-punitive. Hammond said it would be bad taste for him "to sound off against the doctor." Turner, protesting confusion, said his complaints had taken the form of telling himself that the doctor was incompetent. ("It's like a dependent boy saying mamma isn't doing *everything*.") West asked for drugs to facilitate expression of his feelings. Steele said that his previous doctor had been an older man. Trill: "My resentment of K has been slight." Dr. K observed that small resentments, if not expressed, can get so big that they can't be expressed. Turner then went on openly to speak of resentment of the doctor's type of leadership: "I felt that I got it in the neck when I did bring out my feelings to Dr. K." He said he had felt that the doctor was sadistic toward him, that most of the doctor's suggestions were strictly textbook suggestions, and that he did not like to be treated as an average man with an average background. When another patient said that he too had been blocked in free association, Turner repeated, "I try to appease the mad beast over here with tidbits" (referring to Dr. K). The meeting concluded with Hammond, Mercer, and West complaining that they had been unable to lay problems before their parents as children.

In Meeting 13 the patients spontaneously brought up the topic again. Dr. K replied, "I think it would be useful to express these feelings about me." Trill, who had previously been the most blocked, at first said that his antagonism was based on wanting the doctor to take a more active part. "Another thing I resent; he's always so God-damn ready to back down instead of taking a stand. . . . It's the way he's so humble—like a Jap—'so solly'—when you kick him in the teeth. Am I being clear?" Trill went on to say that he was similarly irritated with his wife because she seemed to have no plan. Then he complained about the passivity of a girl friend. Turner: "If she asked to do something with you, it would raise your self-esteem—just as if Dr. K would take a stronger lead with me I'd feel, O boy! he thinks something of me." In later meetings expressions of resentment were more often associated with new insights and less often merely complaints.

DISCUSSION: The situation analysis seems clearly to demonstrate how hostility may be directed against the doctor because of a resemblance

to significant persons in the patients' lives. The particular character of the hostility directed against the doctor seemed determined to a considerable extent with each patient by the doctor's apologetic manner and his hesitancy in assuming open responsibility for the group. For these reasons the patients felt called upon to protect him. The doctor correctly surmised that the group was suppressing anger toward him and recognized that he should try to bring it into the open. It may be that since he took the initiative in bringing it out, he felt that he was in control of the situation and therefore could accept the hostility. This active acceptance appeared to have facilitated expression of fears of passivity behind the anger and removed a more general block to collaborative study with these patients of their difficulties in living.

In Situation Analysis 16, when the doctor was defensive in the face of attack, the group defended him and no movement occurred.

### *Situation Analysis 16*

#### *DR. K's GROUP, Meeting 27*

PRESENT: Malta, Mulican, Hammond, Mercer, Turner, Rothschild, Sloane, and West

SETTING: Dr. K was a somewhat insecure, intellectual person who had asked for the free expression of hostility but was not fully prepared to accept it. The patients had a relatively low tolerance for tension. Mulican, a large, blustering, explosive man, had upset the group considerably with an attack on the doctor in Meeting 14. He concealed his marked anxiety by an air of confidence. He opened Meeting 16 with another attack on Dr. K, demanding to know what he (Mulican) was getting from group therapy and disapproving the doctor's technique of dealing with problems of individual patients in which the others were not interested. Malta tried to defend group therapy by maintaining that one profits from seeing others in the same trouble. Rothschild, Mercer, and Hammond joined him in this effort, while Turner suggested that Mulican was trying to test just how far the group would let him go. Mulican continued to make belligerent remarks such as, "I don't give a damn what you fellows say about this." He referred sarcastically to "men of letters, like Hammond here." When asked by Dr. K to investigate his feelings, he gave an angry and obscene refusal. Everyone was upset. Dr. K seemed uncomfortable. Hammond seemed to be struggling to find words. Rothschild tried to offer an intellectual formulation of what was occurring. Mercer, flinching and frowning, said that it made him feel good to

see Mulican expressing his feelings, because then he knew he would be able to. Mulican launched into an attack on the ineffectiveness of therapy.

EVENT: Dr. K responded with more than a trace of anger in his voice, "You have defined what you have gotten out of this session," then hastened to assure Mulican that he had been benefited by treatment.

EFFECTS: Rothschild, Malta, Mercer, and Hammond came to the defense of therapy. Turner said he believed Mulican was not serious but was merely testing how far the group would let him go. At the end of the meeting Hammond half-heartedly tried to suggest that Mulican had finally accepted Dr. K's original position. West and Sloane seemed paralyzed throughout and did nothing. Dr. K later reported being quite anxious during Mulican's outburst.

In Meeting 28 the group devoted most of its efforts to getting the doctor's support in the form of requesting sedation and hypnotherapy. When Dr. K asked, "Wouldn't you feel like an ass if your difficulties could be solved in a few minutes?" all agreed that they would "like to be asses" and continued their efforts to establish a dependent relationship.

DISCUSSION: Meeting 27 was exceedingly tense. Mulican's belligerent attacks on everyone including Dr. K made the group anxious. When Mulican attacked the ineffectiveness of therapy, Dr. K first indicated irritation and then became defensive about the value of treatment. Other patients joined in defending therapy or trying to minimize the seriousness of Mulican's attack, and nothing was accomplished.

TENTATIVE DEDUCTION: Here the doctor blocked progress by being openly annoyed at a patient's anger and then immediately defensive about therapy, which diverted the rest of the group to a like defense.

In Situation Analysis 17 the doctor, by trying to analyze a patient's anger and questioning its genuineness, impeded its full expression and caused the group's tension to mount.

### *Situation Analysis 17*

#### **DR. K's GROUP, Meeting 29**

PRESENT: Turner, West, Rothschild, Mercer, Hammond, Theodore, and Mulican

SETTING: The group had been struggling with the problem of expressing emotions since Mulican's recent outburst (see Situation Analysis 16) which was still on the minds of the members, who referred to it in private sessions.



The central patient, Hammond, a big man with a booming voice who expressed emotions freely, saw himself as a small boy needing the attention and acceptance of others. He placed high value on his intellectual ability, about which he was uncertain, and tried to avoid consideration of his emotionality. Rothschild, his chief opponent today, was an unemotional, intellectually penetrating person who frequently made telling interpretations to others without showing much of himself. He said that he felt intellectually superior to the others.

In Meeting 28 Rothschild had upset Hammond by asking him how he had felt when another patient contrasted him with the intellectually capable Turner and likened him to the emotionally uncontrolled Mulican.

In Meeting 29 Rothschild said he would rather be disliked than liked by Hammond and Mulican because of their emotionality. He refused to explain or elaborate despite persistent efforts of the others, including Hammond, to draw him out. Hammond expressed his disturbance at Rothschild's attitude by saying, "I'm not accepted here." When this bid for attention and reassurance was ignored by Dr. K, who turned to another patient, Hammond broke in with mounting agitation to tell about defeats he had suffered in his childhood. Later he said, "I don't like the way I'm reacting. I would like to be able to take it or leave it. All the anxiety I ever felt wants to break loose. I want to get up and get out." He expressed anxiety over an earlier discussion about who was the doctor's "favorite child." Then he tried unsuccessfully to get others to express their feelings about him, finally shouting at Mercer, "If you've got feelings, express them. Why the hell don't you say so!" Rothschild, penetrating to the real issue, asked Hammond how he felt when the conversation drifted from him. Dr. K asked whether the need to suppress anger burned Hammond up. Hammond, referring to another patient, said, "There are some who want to hide and talk too." He added that he felt like throwing his weight around physically.

EVENT: Dr. K in an intellectual way tried to determine the basis for Hammond's anger, while implying that it was not genuine. He asked whether Hammond felt "called upon" to get angry, and Hammond replied that he was angry about listening to a lot of stuff that wasn't important to him. Dr. K wondered whether anyone had tried to provoke Hammond, which Hammond denied. When the doctor suggested that Rothschild had done so, Hammond replied forcefully, "Yes, in the old days that would have called for a fight, and later on I would have expressed contempt for them." Dr. K: "And the group would have praised you, eh?" Hammond: "Yeah!" Dr. K: "You felt expected

to get angry, eh?" Hammond, sarcastically: "Yeah, I was bored, and this was an off day." The doctor asked him about the "off day," but Hammond replied angrily, "What's the use?" He added that his sensitivity made the darts strike deeper. The doctor then asked whether Hammond felt called upon to defend himself.

EFFECT: Hammond looked at his watch and said, "Well, I've got to go," rose and left the room, slamming the door violently.

DISCUSSION: The group had a history of violent expression of anger. The doctor had stated to a senior staff member that he was afraid of violence in himself and others and of Hammond's in particular. He recognized that this was at least in part due to his fear of releasing his own strong destructive tendencies. Superficially the doctor's behavior was different from that shown in the preceding situation analysis in that he consciously tried to accept Hammond's anger and help him analyze it. In so doing he actually prevented the analysis by repeatedly interrupting its expression and by not accepting it as genuine. ("You feel called upon to be angry?") Thus to the patient's neurotic anger was added the anger caused by frustration and implied belittling.

TENTATIVE DEDUCTION: This illustrates how the doctor's fear of an emotion caused it to increase and prevented its analysis, although the doctor thought he was using appropriate techniques.

In Situation Analysis 18 patients went through progressively more intense and direct attacks on the doctor, facilitated by his objective examination of these attacks and his continued security.

### *Situation Analysis 18*

#### **DR. K'S GROUP, Meeting 65**

PRESENT: Rothschild, Mercer, and Turner

SETTING: For more than a year there had been a feud between Mercer and Turner. Turner had strenuously attacked Mercer's role as a "model child" and a "favorite son." Mercer had accused Turner of conducting a planned campaign of frustrating him. There had been little or no direct involvement of Dr. K in this matter, Turner never blaming the doctor for Mercer's role, and Mercer only suggesting that it was the doctor who might be frustrating him. For several months, however, Mercer had been concerned over his artificiality in the doctor's presence and had indicated some partially concealed resentment toward him. Turner had had a disturbing hour with Dr. K during the current week (see below). Rothschild had several times seemed to compete with Dr. K for the role of therapist.

In Meeting 64 Turner had attacked Mercer and almost reduced

him to tears by insisting that Mercer was not spontaneous. At today's meeting Mercer and Turner again picked up their discussion of homosexual feelings toward each other from the previous meeting.

EVENT: Dr. K remained secure as Turner expressed irritation with him and tried to elicit further feelings from the patient.

Early in the meeting Turner and Mercer had said that they could go no further. Dr. K asked if they were embarrassed before someone, and Turner replied, "Yes, you." He went on to tell how his private hour had been disturbing to him and how he felt that Dr. K had attacked him in a "bestial and vicious" way. There followed a long discussion between Mercer and Turner, dealing with Mercer's transference of attitudes toward his mother to Turner and *vice versa*, until Mercer said in desperation, "This sort of stuff can go on from now on, over and over again." Dr. K asked Mercer whether Turner was the only one who prompted his response. When Mercer asked what sort of an answer the doctor wanted, the latter said that he felt the men were pushing their feelings well below the surface. Turner very belligerently asked Dr. K whether he had any idea of what sort of feelings they were keeping down, and the doctor said he was not sure. Turner kept pressing him for a reply, and the doctor suggested that perhaps Turner was angry. Mercer said this was the only kind of resentment that Turner had ever expressed since they had been there. Dr. K then suggested that they kept themselves in a mildly irritated state.

EFFECTS: The patients were able to criticize the doctor with increasing directness and relevance while he remained secure, but they became briefly uneasy when he was apologetic.

Mercer said that they did this to satisfy the doctor, adding, "Yeah, when you ask me what it is I feel, I feel as though I have to put on a fuss." Turner was relieved to hear that he was "angry" rather than expressing affection. However, he soon maintained that he had acted angry for the doctor's sake. When Dr. K asked, "Is this supposed to alter my feelings?" Turner accused the doctor of "derailing." Dr. K replied that this statement might be valid. Turner said that the doctor was insatiable in his demand for the expression of feelings and that in order to satisfy him it would be necessary for Turner to stand on his head. Mercer expressed concern over the tendency to "start out with analysis" and suggested that the patients needed more social contacts. Rothschild suggested that perhaps Dr. K was too quick to ask for analysis. Turner took up the attack by saying, "I don't know, just a few minutes ago I felt frustrated as though we were going around in circles, but I was afraid to say anything about it because

you would possibly analyze hell out of it." Dr. K remarked that he was trying to help but felt frustrated himself at times. Mercer reported that he had greater freedom outside of the group. Dr. K indicated that there was a necessity for both sorts of activity, the social and the analytic. Turner recalled that there had not been much of the former, and Mercer wondered why they had to be separated. Turner suggested that it put people on the spot to have to come in and report, and Dr. K agreed, saying, "I know, you're all in a spot all the way through psychiatric treatment." He suggested that both men might be trying to keep down their strong feelings and "to frustrate" the doctor. Mercer indicated his confusion, not knowing whether he was supposed to analyze, or what. He grew quite upset about not knowing what to do, and Dr. K said, "I think I've set myself up to help you. When it becomes necessary to be spontaneous, you proceed to be as spontaneous as possible. It seems to be that any way of frustrating me will do."

Turner then asked Dr. K, "Do you feel comfortable about your ability to promote spontaneity?" The doctor replied, "There isn't much evidence of my success." Turner said that the doctor was attempting to frustrate the group. Dr. K asked what led to that conclusion, and Turner answered, "You ask for spontaneity and then make it difficult to be spontaneous by asking about it." He said that he wondered if becoming a psychiatrist wasn't a good way of venting hostility. Dr. K asked how he had made it difficult for Turner to be spontaneous, and Turner said, "By asking me to be reasonable." The doctor repeated his question, and Turner replied, "You're giving support to my charge." Dr. K said that he was trying to be as helpful as possible, and Turner remarked that he didn't know about that. Dr. K again asked how he had made it difficult. Turner said, "This method of requesting feelings just makes it less spontaneous. You find out how we aren't." Mercer tried briefly to protect the doctor from what he thought was a personal attack, but Dr. K said, "So I'm at fault for all this; well, I'd like to put it to rights."

Turner became a little uncomfortable about his "idol-smashing." Both men agreed that it would be good if they could convince themselves that the doctor did not want to take out hostility on them. Turner: "I wonder how aware the doctor is of his own hostility to me." In subsequent meetings the group continued to express their hostility and their general feelings toward the doctor in a more direct fashion than they had been able to heretofore.

DISCUSSION: This meeting differs from those described in Situation Analyses 16 and 17 in that it occurred eight months later, the two



most openly angry patients were absent and the doctor's own analysis had proceeded. The doctor was able to facilitate the expression of hostility toward himself through genuine acceptance of it. This made it possible for a patient clearly to state how the doctor had been blocking therapy and then to suggest the doctor's own problem with hostility. This freedom of expression persisted for the most part, although when the doctor occasionally went back to his old pattern ("So I'm at fault. . .") the hostile patients became uneasy as before.

In the following four situation analyses expression of hostility toward the doctor led to a therapeutically useful outcome. In Situation Analysis 19 the doctor's security facilitated members' expression of hostile feelings and so dissipated them.

### *Situation Analysis 19*

#### *DR. N'S GROUP I, Meeting 74*

**PRESENT:** Coombs, Eubank, Gugis, Milton, and Trippitt

**SETTING:** In recent meetings patients had begun to talk of their feelings toward the doctor. In Meeting 72 Coombs had identified him with a parent.\* In Meeting 73 Trippitt had said that the doctor was cold like his father and had stressed his own need for affection. Gugis had criticized the group and the doctor for not helping Trippitt more. Coombs had recurrently attacked Trippitt for his intellectuality and air of superiority. He particularly resented Trippitt's acting like a therapist. The group seemed to be in a period of rising tension with more open expression of anxiety and negative feelings.

Coombs, continuing his theme of wanting to be rejected because he saw this as a way of punishing the rejector, had said in Meeting 73 that he wanted "to have nothing to do with nothing" and that he did not want to participate. Dr. N asked him why, then, he kept on coming. Coombs said defensively, "That's the way I am, but it doesn't seem an ideal way of being. I'm in a hell of a fix." He then attacked therapy, saying he felt that it had gone beyond what he came for. All he wanted was to be relieved of his depression. If he were to get well—that is, if he were to be anything but a pig—his family would bask in reflected glory, and this he wanted to avoid.

Coombs came to Meeting 74 very much disturbed and talked unclearly about a dream which indicated concern over assuming responsibility; it involved payment or non-payment of bills, and also being outside of the group. From this he went on to an attack on

\*See Situation Analysis 39.

Trippitt. He said that he no longer felt that he was getting anything from Trippitt, because Trippitt got everything from the doctor. He had also come to feel that he couldn't get any more out of the group. He recalled the doctor's asking him why he continued to come and said that he thought maybe he came partially to placate the doctor. Dr. N asked him if the question had seemed hostile. Coombs, his voice rising and whining, replied, "You're trying to make me give up a position I've maintained all my life." He said the doctor was treating him as though he were not sick. He then attacked Trippitt in a confused way for some time, bringing up old complaints about Trippitt's attitude of intellectual superiority toward the rest of the group.

EVENT: Dr. N said that it looked as though Coombs were talking about Trippitt instead of the doctor, and he explained that the question he had asked Coombs at the last meeting was not hostile but a simple inquiry. Coombs said that he recognized the question was merely an inquiry but pointed out that he was not rational. Gugis said that he thought the question *was* hostile. Trippitt said that he thought the doctor's question had "just enough taunt in it" to get a rise out of him. Dr. N turned to Gugis and said that he thought Gugis was right, that he had been irritable that day. Dr. N then asked Milton what he thought about the question, and Milton replied that he thought the doctor was "just persisting" and had been after him that way sometimes too.

EFFECTS: Hostility and tension seemed dissipated and the group moved on to other problems. Gugis said that it seemed funny how a little thing like a hostile question could bother him for a long time, and how it seemed to him that hostility had been there. Dr. N asked him what sort of things made him hostile, and Gugis brought up homosexuality, which he had discussed in private session with the doctor. Coombs showed that he had recovered from his disturbance by the ease with which he allowed the subject to change and the way in which he joined in the discussion of others' problems.

In Meeting 76 Coombs showed no signs of being emotionally disturbed. He participated actively and with insight. Trippitt became involved in a discussion of his attitude toward his family. Although "on one side of the coin" he felt that they were responsible for his being neurotic, "on the other" he forgave them. Coombs said that Trippitt had not described the reverse side of the coin correctly; he explained that on the one hand the parents were responsible and on the other Trippitt himself was responsible. He laughed and said that Dr. N had been trying to tell him this about his own case but he hadn't been able to see the point up to now. He had not only got

over his anger at the doctor, but had also accepted an interpretation which had previously been too disturbing for him to take.

DISCUSSION: Coombs was angry at Dr. N because he had sensed irritation of which the latter was not aware. After Coombs tried briefly to express his feeling aggrieved, he displaced his anger with Dr. N upon Trippitt, because his being angry at Trippitt was an old and accepted pattern. Dr. N called attention to the displacement and re-directed attention to the original irritant in a somewhat defensive way.

The patients felt as free to challenge the doctor's statements as to question one another's. When several patients agreed that he had shown irritation, he recognized that they were right without any defensiveness. This dissipated the patients' hostility and tension, and they were able to go on to the profitable examination of personal problems.

This situation illustrates how the doctor's position can change from that of a person apart to one whose human failings can be discussed in the same terms as the patient's. For the patient this is an important therapeutic experience. It is possible that it is more easily brought about in group than in individual therapy.

TENTATIVE DEDUCTION: Here we see that the doctor in accepting a justified criticism comfortably ameliorated tension to the extent that the patients were able to go on with the examination of more pertinent problems.

In Situation Analysis 20 the doctor facilitated therapeutic progress by encouraging expression of negative attitudes.

### *Situation Analysis 20*

#### **DR. N's GROUP I, Meeting 83**

PRESENT: Coombs, Eubank, Trippitt, Milton, and Gugis

SETTING: Hostile relationships had developed between Trippitt on the one hand and Coombs and Gugis on the other. The reasons for this hostility had been analyzed. The patients had become less hostile and more intimate on the whole, and positive feelings had been expressed. Although the patients were dependent on the doctor, they were able to express anger toward him directly.

Gugis, the central patient in this situation, was able to show almost no emotion but hostility. He characteristically became angry when another patient, with a problem related to one of Gugis', had worked it through himself. In past meetings he had stated that only hostile feelings were valid, and his feeling of worthlessness had also come out strongly in the group.

The group was concerned with feelings of being insignificant or ignored and of being unable to do what is required to maintain a relationship. In Meeting 81 Coombs had attacked Trippitt on the ground that Trippitt didn't know what to do until the doctor indicated it to him. Trippitt, upset, denied this and indicated that he did not feel he belonged in the group. Coombs later complained that when he expressed anger in the group, it made no impression. What he said didn't count. Eubank had taken up the whole of Meeting 82 with a related problem in connection with his mother-in-law, with whom he felt "left out, ignored, and insignificant." He wanted to do something to interest her but felt incapable of doing it. Coombs related Eubank's problem at home to his problem in the group, where he seemed to be afraid of talking for fear of not being interesting to the others. In Meeting 83 Coombs questioned why the doctor helped the patients—"What are his motives?" Coombs wanted to escape from the relationship, which could come about only through violence to the doctor. He felt enslaved by the doctor. There was a general discussion of the doctor as "God."

After this discussion Gugis asked the doctor, "Why the hell don't you drop the whole group and get a new one? The only one getting well is Milton. I've never heard such bitches and grippers." He said that Dr. N saw the patients just because they came.

EVENT: Dr. N helped the group to bring out and discuss negative feelings toward him. He asked for Milton's feelings about this, and Milton said that if Dr. N were getting paid by the patients, he could string them along for years. Gugis asked Milton why Dr. N should go on listening to patients "bitching about his treatment." Everyone spoke at once, Eubank, Trippitt, and Coombs all protesting against Gugis' comments. Trippitt observed that it sounded as if Gugis were saying that "Gugis is just dust," only he included the whole group. Gugis asked why the doctor should spend his whole life trying to change five individuals. Eubank pointed out that two patients had left the group well. Dr. N said that they might examine the attitudes of all members of the group. He reminded them that Coombs had said that the doctor continued with the group in order to keep the patients all enslaved. Trippitt volunteered that Dr. N didn't care whether they got well because he was "so utterly free." Dr. N then asked why Gugis felt the doctor should throw out a man who was not getting better.

EFFECTS: In the ensuing discussion it developed that Gugis felt his griping was an indication that he was not improving. Coombs suggested that Gugis felt he had no "facts to contribute." Gugis associated this with his having no feelings and said that feelings had



emerged in his fantasy life. He was then able to talk about his inability to express feelings for fear people would not believe they were genuine. Dr. N was then able to help Gugis see the relation between early childhood experiences and this attitude. Gugis connected it with his being caught between parents who thought of separating and with his feeling helpless, like a pawn. He could express his will only by whining, and no one paid attention to what he said. His problem was to keep his mother's love, which was best done by being helpless. He also felt that it was safer to keep his mouth shut, so as not to be "found out." His attitudes as a child at home and in the group were seen to be comparable. In concluding the meeting Dr. N summed up by saying that he thought the patients understood more clearly why Gugis had the reaction that "his feelings don't count."

**DISCUSSION:** Gugis' attack on the group and the doctor sprang from his self-hate, a feeling which was similar to those of the others. With much emotion they first attacked Gugis and then joined his attack on the doctor on the ground that since they were no good the doctor must have ulterior motives for his interest in them. Gugis, by bringing about the identification of the group with himself, obscured the personal problem which lay behind his attack. The doctor remained unaffected and helped the patients to express their self-hate and bitterness. This reduced the tension to the point that it became possible to focus on attitudes underlying Gugis' original attack.

In this situation dealing realistically with present behavior facilitated the examination of past experiences which cast light on the present difficulty.

**TENTATIVE DEDUCTION:** As in the preceding situation analysis the doctor focused on the meaning of the hostility instead of reacting emotionally to it, and so gave the patient an opportunity to bring out experiences relevant to his behavior.

In Situation Analysis 21 the doctor remained secure under prolonged attack by a patient. This led to a rise in group tension which eventuated in therapeutically useful experiences for two patients.

### *Situation Analysis 21*

**DR. N's GROUP II, Meeting 67**

**PRESENT:** Bly, Castell, Veal, Ingram, and Coombs

**SETTING:** Attitudes toward Dr. N had been largely negative for the past five meetings, perhaps because of his previous absence on a month's vacation and the entrance of a new patient shortly thereafter. In the last two meetings there had been considerable verbalization

of hostility toward the doctor and toward Bly. Dr. N had encouraged and been acceptant of negative feelings. Bly, one of the chief participants, was extremely facile in verbalizing his hostility toward the doctor and did so more frequently than any other patient. He tended largely to ignore the other group members and to talk directly to Dr. N.\* Three meetings ago he had been attacked by almost all the others for monopolizing the doctor's attention.

Veal, the other chief participant, rarely spoke and then usually to advise others or show himself in a good light. He avoided recognition of hostility in himself or others and seemed eager for doctor's approval. During the early part of the meeting there were many silences; Dr. N remarked that the group seemed pretty tense, as it had for the past several meetings, but got no direct response. Shortly afterward Bly began telling of his resentment against his wife and the doctor. He continued to address the doctor, disregarding others' attempts to comment on what he said. He discussed his feeling with Dr. N that the latter treated him like a child and would not put all the cards on the table and be honest with him. Dr. N wondered if the idea which was intolerable to Bly was that the doctor did not know the answers. Bly admitted that this was so. During the long discussion other patients became increasingly restless and annoyed. After almost an hour Castell blurted out angrily, "What's annoying hell out of me is that he's (Bly) picking on you (Dr. N). It's bothering me something awful—it makes me damn mad." Veal said, "I feel the same thing; I have a headache because of it." Castell said that he had, too, and Veal continued, "He (Bly) is acting like a child and says he wants to be treated like a man—actions speak louder than words. If he wants to be treated like a man, he should act like a man."

EVENT: Dr. N calmly commented that Bly's tearing down the doctor seemed to bother Mr. Castell and Mr. Veal. He asked how the others felt about it. Ingram said that he agreed with Bly that it was impossible to get an answer from the doctor. It seemed to him that the latter was putting Bly in an inferior position by assuming that he could not stand to hear the truth about himself. Dr. N pointed out to Bly that Veal had said that if he would act like a man, he would be treated like a man. Bly asked how Veal would know. Dr. N said that these were Veal's feelings and attitude and that the group had to look at them also.

EFFECTS: Bly replied angrily, "I feel like I would blow up now. . . ." He likened Veal to his father, who said, "Snap out of it—don't be a damn fool—be a man." He said that he got mad when people tried to

\*See Situation Analysis 11.

tell him what to do and wanted to ask them why they didn't overcome their own weaknesses. He especially resented Veal's statement, since Veal had never brought out anything about himself. Dr. N congratulated Bly on his first expression of anger toward another patient without backing down. In a subsequent meeting Veal spoke at length about himself for the first time.

DISCUSSION: By accepting the content of Bly's criticism and dealing with it realistically, Dr. N permitted interactions to develop productively. He did not interfere as tension increased to the point where two patients became so uncomfortable over Bly's attack that they opposed him in the doctor's defense. Bly, possibly on the strength of Dr. N's acceptance and Ingram's agreement with him, was able for the first time to attack another patient, Veal, on realistic grounds, without subsequently backing down. This was a real gain for him. The doctor's praise of Bly for criticizing Veal's reticence may have indicated to Veal that the doctor agreed with the criticism. He subsequently talked about his own problems, perhaps to get the doctor's approval, which was very important to him.

Dr. N's objectivity permitted the patients to take sides against each other. The fact that the issue was first expressed in terms of attitudes toward a third person (the doctor) may have made this easier. This phenomenon, which obviously cannot occur in individual therapy, can be useful in helping patients learn to stand their ground when opposed and in bringing out hitherto hidden significant attitudes.

TENTATIVE DEDUCTION: This situation illustrates how the doctor's objectivity in the face of an attack on him permitted the expression of antagonisms which proved therapeutically useful.

In Situation Analysis 22 the doctor's remaining secure while encouraging expressions of criticism facilitated discussion of these feelings.

### *Situation Analysis 22*

#### *DR. Z'S GROUP, Meeting 22*

PRESENT: Phillips, Stafford, Kootch, and Giordano

SETTING: All the patients were in conflict over problems of dependency and responsibility. When they attacked doctors, and Dr. Z, feeling insecure, nevertheless tried to draw them out, they went off into generalities and irrelevancies.

Phillips, an ambulatory but often paranoid schizophrenic, had been reluctant to join a group because of a fear that others would gain power over him by learning about him. He told the group that he

could only be friendly with one who had told him so much about his problems that he would not be in a position of advantage. With the doctor he had come to question this as a valid basis for friendship. His attitude toward the therapeutic relationship was that when he put himself at the mercy of the doctor the latter became responsible for his actions and to blame for any setbacks.

Giordano, who had been psychotic, generally spoke in terms of vague feelings which he rarely tied to events. When made anxious by those who were able to command Dr. Z's attention with a well-told anecdote, he complained of the powerlessness of a baby to do other than demand help. He had expressed guilt feelings about coming to the clinic for help and both fear of and desire for dependent relationships.

Stafford, an obsessive, traced his problem with dependency feelings to the overprotectiveness of his mother: "In my own case I was given no responsibility—my mother thought it better for me that way—I never bought my own clothes until out of the service. Then I revolted against my mother buying me things. This was probably wrong."

Kootch dealt with others by trying always to appear in control of situations. In the group he was contemptuous of those who "let their hair down." He had not enjoyed the isolation to which this attitude led and stated at Meeting 14 that he had to act in this way because he could not bear being a weakling like his father.

In Meeting 19 patients discussed their conflicts over seeking or accepting help. Phillips: "I very often want all those things done for me but resented having them done for me in the service." Stafford: "I resented having my mother wanting to buy my clothes. That seems to contradict my wanting guidance." Phillips: "I want to take what they've got but don't want to pay the price." Giordano: "I've learned to be dependent, but don't want to. At school I get in a little problem, then run to the teacher right away." In Meeting 20, when Phillips expressed his hesitancy about being interviewed by the social worker, Dr. Z had pointed out that Phillips was setting up different rules for the social worker and the doctor. Phillips, Kootch, and Stafford agreed that doctors could make mistakes, while Giordano said that he himself needed help so badly that he was not in a position to object. At Meeting 21 Phillips had told of being afraid that he would make the dentist uncomfortable by showing pain and so lose his regard. Giordano: "If he overcharged you, could you argue?" Kootch: "What do you care what he feels about you; are you ever going to see him again?" Phillips: "He doesn't want to cause you pain and you don't want to make him feel unsure of himself."



In Meeting 22, when Giordano proposed doctors as a standard for healthy personalities, the group rejected the idea. Stafford: "Plenty of doctors are incompetent." Kootch: "They might not be any better at their jobs than you are." Phillips said that he had seen examples of doctors' incompetence in his work with military medical records. Stafford: "A doctor could screw you up and the only one who'd know would be another doctor." Dr. Z: "I wonder about this talk today about doctors' ability." Kootch: "I think it's outside our competence." Dr. Z: "I think there's a lot to be said about doctors' errors, nervous doctors." (Dr. Z later reported that at this point he was somewhat uneasy.)

Stafford said that his strong reaction was based on dissatisfaction with working in an office with doctors who stand on their professional dignity. Kootch: "I don't think he's any better than anyone sitting here in this room." Phillips flushed, and Giordano defended doctors ("They helped me out of a tight place"). Kootch then attempted to shift the discussion to the subject of whether they would feel the same about a lawyer, and the group agreed that this was a tangent. Dr. Z pointed out that after he had commented on their talking about doctors' failures there had been shifts to four different topics—"What goes on here, what doubts did you have?" Stafford: "Doubts about what?" Dr. Z: "Doctors, I should say." Kootch said laughingly, "Giordano has no doubts," and added, "I don't see how you (Giordano) can place such blind faith." Giordano: "You weren't in the spot I was." Phillips answered Kootch's earlier question about lawyers by saying that the important difference was the fact that the doctor deals with human lives.

Dr. Z later reported to the observer that at this point he had worked through his own insecurity about the topic. He had felt until now that it was too early for the group members to face their doubts about therapy. However, he now felt that the attitudes of all the patients had been expressed fully enough to be profitably examined.

EVENT: Dr. Z again asked the group to consider the kind of thing they were saying about doctors and reviewed some of them; he then mentioned that the patients had joined the group to do something about their lives.

EFFECTS: The patients at first rallied around their difficulties in seeking help from Dr. Z, then Phillips analyzed his difficulty with the doctor as a part of his problem with dependency, leading to considerable clarification of what had been impeding him.

Giordano responded that the attitude was "a need for support, for someone like father." Phillips: "Are you referring to Dr. Z?" Giordano:

"To him and all the other doctors. I couldn't work it out myself." Phillips: "Is Dr. Z helping you in this respect?" Giordano: "I can't ask him to answer my question. I've got to work it out." He spoke of wanting attention, needing approval, "going around in a circle thinking about it." Phillips spoke of his irritation with Dr. Z's not doing anything. ("I must have wanted some pills from him.") Kootch said that he had had the same experience and had discovered that he had to figure it out for himself. Stafford said that like Phillips he expected one word to solve his problems. Giordano spoke appreciatively of having come in mixed up and not having been rejected and added that now he felt a lot better.

Phillips: "All that talk before about incompetent doctors, was that really a hidden criticism of Dr. Z? . . . Perhaps I resented going to the doctor—having to put him in a godlike position." Kootch replied to Phillips contemptuously, "Speaking for yourself?" Phillips: "Perhaps for all of us." Dr. Z: "I think we should go into that." Kootch: "Phillips feels resentful about having to go to doctors just as he resents the social workers." Dr. Z: "Maybe so. How about that?" Phillips: "Maybe it was the social worker's learning something about my private life, but I think it was having to put him in the paternal position and my resenting authority." Dr. Z asked whether he felt the doctor would despise him for what he despised in himself. Phillips concluded that it put the doctor in a position of advantage ("Knowing my shortcomings when I don't know his, then having to come and shift my burden to him").

DISCUSSION: The doctor's encouraging the patients in an impartial way to examine further their critical attitudes toward him seemed to have facilitated a mutually supportive discussion of these attitudes. This helped Phillips to elaborate his expectancies from the doctor and the distortions in his past attitudes. The patients' original evasiveness may have been a reaction to the doctor's initial insecurity, which he reported after the meeting but which was not apparent in what he said. As in the preceding two situations the doctor's neutral attitude permitted the patients to take sides about him.

TENTATIVE DEDUCTION: The doctor's security in the face of attack and his objective interest in it facilitated interaction of the patients' attitudes toward him and helped a member of the group clarify one of his conflicts.

In Situation Analysis 23, in contrast to the preceding four, the doctor reacted defensively to certain patients' anger then invited others to express hostility to him but continued to react defensively. Patients expressed anger with other psychiatric workers but not with him.

*Situation Analysis 23***DR. X's GROUP, Meeting 12**

**PRESENT:** Grey, Hastings, Montgomery, and Rice

**SETTING:** The doctor was active and directive, suggesting topics for discussion and habitually addressing his comments to individual patients. Various members of the group reported personal experiences in connection with a topic suggested by the doctor such as "feelings about giving," offered one another advice, and told of insights gained in individual therapy. That there was tension building up against Dr. X was indicated by the group's failure to cooperate in Meeting 11, when he tried to enlist support for a patient who monopolized the meeting.

The two central patients in this situation were Hastings and Grey. Grey had come to the clinic with acute anxiety symptoms not long after discharge from a veterans' hospital. Dr. X remarked that he brought to the group the fast-moving, sarcastic, competitive, superficially intimate group mores of the radio broadcasting station. At the first meeting he stormed at the rest of the group as former officers and then apologized to them. His rebelliousness against authority was mixed with a feeling that people should have the regard due to their status.

He tried to dominate the group to prevent anything spontaneous from happening and to gain attention. He presented material in well-constructed anecdotes that did not permit interruptions. His attention was sought by Hastings and another patient but he openly rejected them with contempt. Meetings tended to be more spontaneous when he was absent. Hastings, who had monopolized the previous meeting, was the epitome of the popular version of a radio broadcaster—tense, dramatic, sarcastic, and alcoholic. In his early years he, like Grey, had been admired chiefly as a bright and precocious child. In the group he was skillfully ingratiating. He made a special attempt to maintain an identification with Grey, an admired colleague.

At the start of this meeting patients seemed reluctant to speak and there were many silences. Grey said that he did not want to be "the sinner at a revival meeting." Montgomery asked the doctor if he were not about to break the silence. Dr. X: "I can wait as long as you can." Hastings said that he could bring up something but felt it did not concern the group enough. Following encouragement from Dr. X, Hastings told an incident, but Grey interrupted to complain directly to the doctor of being tired. Several briefly described sleepless nights. Grey: "I know you expect me to say a number of things to the group."

When Dr. X questioned this, Grey said that he did not like to be cross-examined and complained that after seven months he didn't see any answers. Dr. X replied defensively, "The fact that I know a lot about you does not get you well." Grey: "You don't get what I mean." Dr. X said that use of information was only good when it was of benefit to the patient. Grey started to speak, then said, "Not today," and added sarcastically, "Dr. X has not yet imparted to me any of the valuable information he has gained."

**EVENT:** Dr. X invited expressions of hostility toward himself but continued to respond defensively, offering inappropriate reassurance and generalization.

Dr. X to Hastings: "Have you felt any antagonism to me?" Hastings: "Not after the second meeting, when several remarks were repeated that I resented. At the moment I don't feel resentful at all. Isn't it natural for a person to feel that way after someone has laid open his mind?" Dr. X, defensively: "If I were just curious, yes, but anyway you'd feel pain." Hastings told about an army psychiatrist who kept his golf clubs behind the office door and who "got slugged" by a friend of his. Dr. X replied in defense of the doctor, "Often the psychiatrist is looking for your reactions." He supported this with an example from his own experience, with rapid screening of enlisted men. Then he asked if Hastings had not identified with the man who struck the doctor. Hastings simply repeated the incident with more justifying reasons for the act. Grey complained that an army psychiatrist for whom he had no respect had designated him "a mild alcoholic who swears a great deal" on the basis that "all radio men drink a lot." Dr. X: "Are you getting better?" Grey: "God, is this going to be one of those deep-seated questionings of why I told that story?" Dr. X: "I had the feeling that Grey was telling me off, and psychiatrists in general, and now feels better." Grey denied this. The doctor offered some generalizations; he then again invited the members to express their hostility to him: "Whom do we get angry at mostly? Sisters, fathers? We don't hate strangers. . . . I want you to realize that we can love and hate people at the same time. . . . I think that at times all of you have hated my guts. Here's a chance to get it off your chest. . . . Let's go around the table on this."

**EFFECTS:** The doctor turned first to Hastings, who admitted that discussion of his twin in individual therapy had irritated him. Hastings: "Main thing is I don't want to argue with you. I want to avoid unpleasantness." Then he gave an example of irritation with a colleague. Grey said that he, too, knew the colleague and that Hastings' irritation



was justified. Montgomery told of his irritation with the social worker, his previous psychiatrist in the clinic, and the psychologist to whom he had been subsequently referred. Dr. X next asked Rice about antagonism. Rice: "I've yet to experience that." Dr. X then went around the group citing examples of patients' irritation with one another, which they denied.

For the next two meetings, contrary to the usual pattern of the group, the patients argued against whatever the doctor proposed.

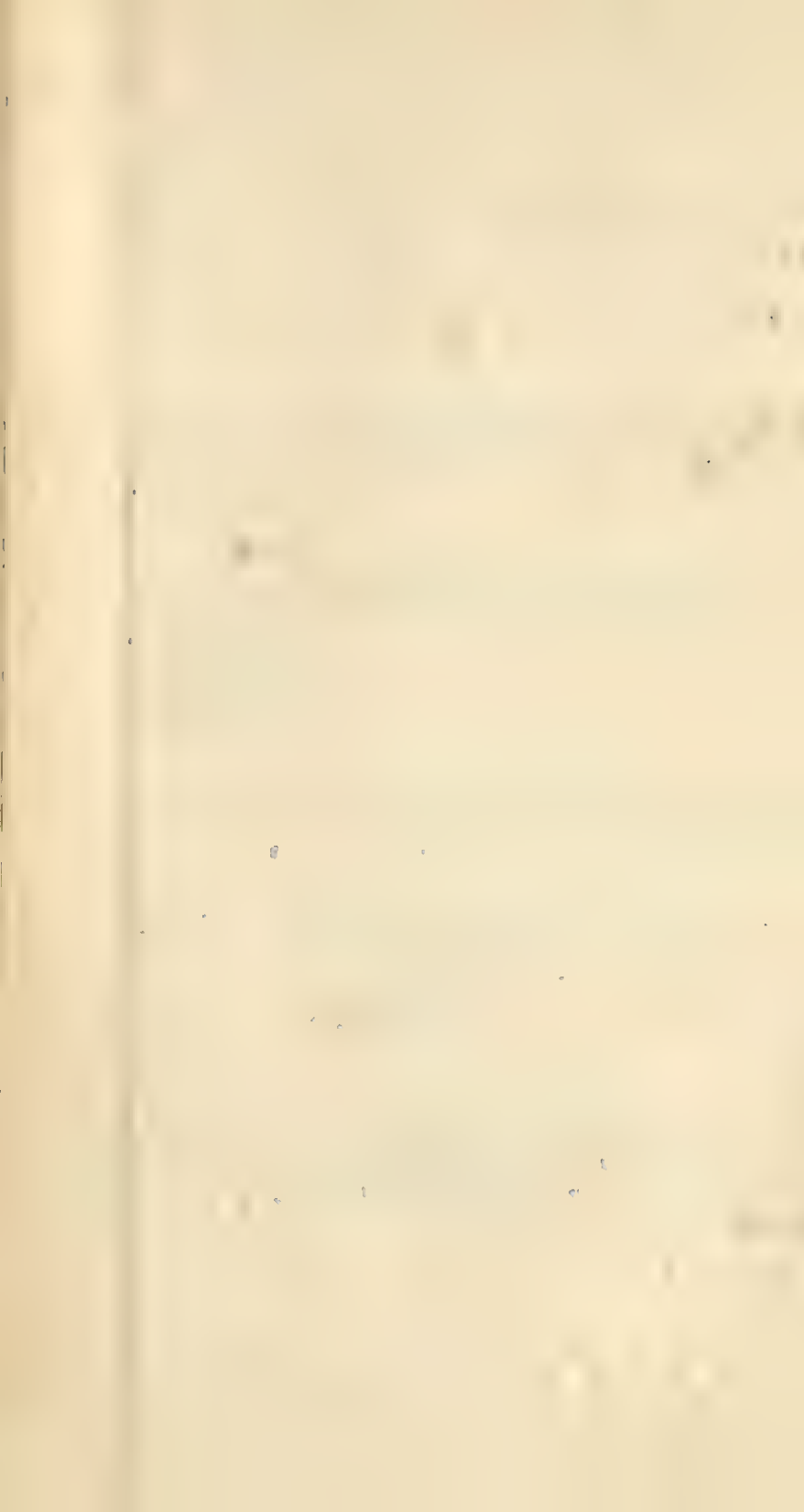
DISCUSSION: A rebellious patient, currently strongly antagonistic to the doctor, was critical of therapy but denied hostility to the doctor. Other patients added their criticisms. The doctor's defensiveness against the patients' expressions of hostility toward him probably conveyed to the patients that he would not accept what he was ostensibly asking for. Despite his statement concerning possible justifiable bases for complaints and the group's awareness of their resistance, the doctor defended himself directly and by generalizations on hostility. This led the patients to displace their anger on surrogates for the doctor without gaining any increased understanding. The doctor's continued activity in directing the patients may have prevented them from gaining enough support from one another to work through their hostility to him in the face of the diversions he made.

TENTATIVE DEDUCTION: In this situation the doctor's defensiveness prevented expressions of hostility even though he asked for them.

Tables 9 and 10 summarize, respectively, the situations in which therapeutic gains resulted from facilitation of expressions of hostility toward the doctor and those in which the tension remained unresolved because such expressions were blocked.

## SUMMARY AND IMPLICATIONS FOR THERAPY

In group as in individual therapy, patients are inevitably dissatisfied or angry with the doctor at some time. These nine situation analyses illustrate how very difficult if not impossible it is for a patient to express and examine such feelings unless he has the support of the doctor and the group. If what he expresses represents the feelings of several members, and if the doctor accepts them and is not made insecure, then the patient, and often other members, can proceed to new insights about these feelings. If the hostile patient lacks the support of the group or the doctor, his attempts to verbalize hostility lead





nowhere, may block the process of therapy, and may result in the others' making a scapegoat of the dissident one, perhaps even driving him from the group.

We do not know whether there are conditions under which the group may work through its hostility toward the doctor despite his insecurity. It is conceivable that a well-established group, having a strong network of interpersonal relationships might feel secure enough to feel and express and resolve hostility together toward a new, insecure doctor.

In our experience an undercurrent of hostility in the group seemed to facilitate therapeutically useful expression by a member. In each of the six examples of successful outcome (see Table 9) a widespread feeling of dissatisfaction with the doctor at that moment seemed to be present, and the patients were struggling to express it. By contrast, in three of the four unsuccessful situations (see Table 10), only one, or at most two members showed antagonism to the doctor, while the others were unconcerned with, or actively opposed, expression of these feelings. In the exception (see Situation Analysis 23) there appeared to be a general undercurrent of hostility as shown by silences. The doctor sensed and tried to get an expression of the anger, but his characteristic questioning of each patient in turn prevented the formation of a consensus among them.

On the other hand, the doctor's ability to remain secure in the face of hostility toward himself and to examine it impartially facilitated a therapeutically useful outcome. Situation Analyses 18 and 22 are particularly instructive in this respect. In Situation Analysis 18 the doctor, as he later reported, at first felt insecure and then at ease in the situation. During the first phase the patients tried to evade expression of their hostility, displacing it from doctors upon lawyers. However, as soon as the doctor was able to feel comfortably acceptant, they were able to express and examine their feelings toward him. In Situation Analysis 22 the doctor did not at first dispute the patients' criticism of him but expressed his own feelings about the matter in a non-defensive way. During this period one patient supported another, who then was able to express his anger. However, after the latter made a really telling point, the doctor showed his insecurity



TABLE 10. Unsuccessful Handling of Hostility toward the Doctor

	<i>Dr. L's Group, Meeting 1 Situation Analysis C*</i>	<i>Dr. K's Group, Meeting 27 Situation Analysis 16</i>
SETTING		
Doctor	Inexperienced in group therapy, uncertain, silent.	Somewhat constricted, intellectual, made uneasy by expressions of hostility.
Group	Struggling to get started. All five members schizoid, asocial. Patients anxious; had not been prepared for group.	Uneasy over Mulican's belligerence (see below).
Significant patients	Connor: had had least previous contact with doctor and only tenuous relationship with him. Doctor knew little about him. Throck: defensive, bullying; aggressive attitude.	Mulican: big, bluff, explosive, concealed anxiety by air of confidence.
Topic or focal interaction	Connor opened meeting by speaking to doctor of intense dislike of officers.	Mulican attacked doctor and therapy in strong terms.
EVENT	Doctor failed to indicate acceptance and appeared to be uneasy and uncertain. (He later confirmed this to observer.)	Doctor became anxious, then irritated, then assured Mulican that he was getting something out of treatment.
EFFECTS	Connor's views were opposed and he was made scapegoat by group, led by Throck as doctor remained impassive. Connor remained silent for rest of meeting, left early and did not return.	All members shaken by Mulican's attack, defended doctor, tried to quiet Mulican or minimize significance of his remarks. At next meeting group tried repeatedly to get doctor's support.

\*S. A. c does not appear in text.

*Dr. K's Group, Meeting 29*  
*Situation Analysis 17*

Same as S. A. 16. Feared Hammond's outbursts.

Same as S. A. 16. Still tense over Mulican's outburst.

Hammond: big, blustering, emotional, prided himself on his intellectuality, craved affection and attention.  
Rothschild: unemotional, intellectual, made penetrating comments to others.

Hammond, increasingly disturbed by Rothschild's rejection of his emotionality and by doctor's failure to give him enough attention, attacked two other patients.

Doctor asked Hammond whether he felt called upon to get angry and whether he expected group to praise him for acting angry.

Hammond expressed frustration and left room, slamming door violently.

*Dr. X's Group, Meeting 12*  
*Situation Analysis 23*

Doctor led the discussion, addressed his comments to individuals.

Becoming restive under doctor's directiveness. General reluctance to speak.

Grey: rebellious, sarcastic, competitive, dominated the group.  
Hastings: radio broadcaster like Grey, had many of same characteristics and identified with him but was skillfully ingratiating.

Grey was hostile toward doctor, repeating his statement that he had got little out of therapy.

Doctor tried to elicit and approve hostility toward himself, but indicated insecurity by being defensive, offering inappropriate reassurance, and generalizing.

Patients expressed hostility toward and irritation with other psychiatric workers, but not toward doctor. At next meeting they opposed doctor's proposals.

COMMON FACTORS

Insecure in face of hostility. See EVENT.

In all groups except S. A. 23, feelings of hostile patient were opposed rather than shared by other members.

None.

Patient directly or indirectly expressed hostility toward doctor or dissatisfaction with therapy.

Doctor manifested insecurity by uneasy silence, by inappropriately reassuring a patient, or by doubting patient's sincerity.

Group failed to support attacker. Tension remained unresolved.

by becoming apologetic and reassuring, whereupon the attacker became uneasy and the other patient went to the doctor's defense.

In each of the unsuccessful situations the doctor showed insecurity or rejection of the patients' feelings, or both. The patients then used their own devices such as humor, intellectualizing, and counter-attack to dissociate themselves from or quell the hostile patient. The frustration arising from not being allowed to express the anger fully tended to increase it. The doctor's insecurity might be shown in various ways, but in each case it appeared likely that the group sensed it.

Since all the doctors were inexperienced in group therapy at the start of the experiment, they felt more certain of themselves in the later meetings than in earlier ones. Also, length of association seemed to increase the likelihood of a consensus of feeling arising among the patients inasmuch as they had had more opportunity to become acquainted and to develop a common background. With two exceptions, our illustrations in Table 9 of the successful handling of hostility toward the doctor came after the sixty-fifth meeting, and the examples of unsuccessful situations in Table 10 all occurred before the twenty-fourth meeting, suggesting that experience on the part of the doctor and continued association on the part of the patients are related to a successful outcome.

These situations make clear that expressions of hostility were potentially useful only if the doctor accepted them and so could help the patient explore his feelings. Furthermore, if the doctor felt insecure, he probably could not avoid showing it no matter how hard he tried—for example, by attempting to analyze an emotion before it had had time to develop or by reassuring the patient. These situations also illustrate the fallacy that the expression of hostility is therapeutically helpful in itself. This was a not uncommon misunderstanding among the less-experienced doctors.

The importance of the doctor's attitude was seen more clearly in group than in individual therapy, since the hostile patient was affected for better or worse by the attitudes of the other patients as well as by those of the doctor. Inasmuch as the patients tended to take their cue from the doctor, the doctor's attitude was magnified, as it were,

by the group. This heightened both the helpful and the detrimental potentialities in his relation to the hostile patient.

It follows that an inexperienced doctor should not encourage expressions of hostile feelings toward himself in the group until he feels able to accept them. This means waiting until he and the group are familiar with each other and he has gained self-confidence. A further advantage of waiting until the group has reached its mature stage is that by that time a network of relationships and traditions will have grown up among the patients. This will tend to mitigate the bad effects of unsuccessful handling of hostility by the doctor and to heighten the effectiveness of proper handling of it. That is, in a more mature group a single patient is less likely to find himself in an intolerably exposed position when the doctor is unable to support him in an expression of hostility. Other patients are more likely to be able to reach an effective consensus with him or to associate profitably to his expressions.



## CHAPTER X

### *Antagonism between Group Members*

---

It is a well-known fact that psychotherapy is accompanied by a considerable amount of open and hidden hostility. In individual sessions the doctor is the only target, but in group meetings other patients may also be objects of irritation, jealousy, envy, anger, and so on. Antagonism between group members often involves their relationship with the doctor, chiefly rivalry for his attention or approval, or hostility toward him displaced upon others, but it sometimes arises more or less independently of attitudes about the doctor. Negative emotions that emerge in the group situation afford excellent opportunities for therapy because they create strain from which most patients wish to escape. The patients feel that they can get relief by searching for the motivations underlying their outbursts, and this in itself helps to allay the counter-hostility of others, since it is in accord with their expectancy.

As might be expected, chronic neurotic difficulties in personal relationships are likely to appear in any group, the degree of overtness with which they are expressed depending on the acceptance of the doctor and the other patients. Since certain patients are more prone to show hostility than others, it appears that the stimulus is not always the immediate group situation, but may be a more deep-seated personal antagonism.

Intra-group hostility is usually expressed between pairs and may persist for many meetings. It sometimes happens that one patient has an obvious attitude that the other has repressed in himself or that one reminds the other of some family member toward whom he is hostile; both factors may be present. In any case, if one patient attacks another long enough, the butt of the attack finally becomes annoyed with the attacker. It may also happen that two patients suffer from

transference distortions in which each confuses the other with a family member about whom he has a conflict. It is obvious that the antagonism will be mutual when each of a pair expresses an attitude which the other hides.

Mutual antagonism may often have an undercurrent of positive feeling, against which the expressed hostility is a defense, especially when based on early ambivalent attitudes toward members of the family. The following example illustrates a patient's anger toward those who expressed feelings which he had repressed.

At different stages of his treatment Coombs attended two groups, in each of which he developed intense hostility to the same type of patient, apparently for the same reasons. As a child Coombs was looked up to by his family for his intellectual superiority and was educated for a profession. He often fantasied himself as God. He gave up his profession and developed an exaggerated humility. However, he behaved so as to permit himself to feel superior under the guise of humility. At the university, for example, he would ask a question which he knew the teacher could answer well. The teacher would feel pleased with himself, and Coombs would secretly be contemptuous of him because he felt he had put something over—he had humiliated the teacher because he had made the latter display a false superiority, the obverse of his own pattern.

In Dr. N's Group 1 Coombs developed an intensely hostile reaction to Trippitt, who was an intellectually arrogant person, also very articulate, but who, in contrast to Coombs, concealed his emotions. Both were very successful at holding the center of the stage and seemed oriented primarily to the doctor. Trippitt upset Coombs most by assuming an air of moral superiority and acting as if he knew what Coombs was thinking. Thus, in the first meeting that Coombs attended, Trippitt said that he avoided prostitutes for ethical reasons. Coombs insisted that Trippitt's real reasons were emotional, and in the following individual interview he went into a tirade about how he secretly felt himself to be superior to everyone and how obscene it was to admit it. He felt that it was most important that no one recognize his superiority. He then spoke of daydreaming for hours, of berating the group in a sardonic tone for their moral smugness. This proved to be his feeling toward Trippitt.

At a later meeting Coombs was furious when Trippitt implied that he could read Coombs' mind by insisting that Coombs' real feelings were the opposite of what he expressed. Actually, Trippitt was right.

This was particularly threatening because Coombs used his own insight into the hidden feelings of others as one of his chief weapons in dealing with them.

In Dr. N's Group II Coombs developed exactly the same type of antagonism toward Bly, an arrogant intellectual with an air of superiority, who dominated the group a large part of the time and rivaled Coombs for the doctor's attention. He resembled Coombs more than Trippitt did in that he also produced a great many infantile fantasies. Bly said that it bothered him to listen to Coombs because the latter looked so pained. Bly felt that he knew what was going on in Coombs' mind, as he had been through it himself before. Coombs angrily replied that Bly had guessed wrong and pointed out that for the second time Bly had acted as if he knew the answers to everything. Both spoke angrily to each other for a few minutes, Bly denying that he had made the statement and Coombs insisting that he had. Bly then said, "Well, I can look at you and see that you are thinking vicious thoughts," but Coombs interrupted him with, "There you go again saying that you know what's in my mind." Bly denied that he had ever used the word vicious or had made the above statement. His denials seemed to be sincere and due to an immediate repression. Coombs' attitude was also colored by his transference reactions. In Dr. N's Group I he confused Trippitt with a younger brother toward whom he was ambivalent.\* In Dr. N's Group II Ingram became the younger brother, and Coombs felt called upon to "protect" him from Bly's attacks in a patronizing way which Ingram perceived as unfriendly.†

In such situations the feeling between the two patients must reach a pitch of intensity strong enough to motivate examination of its source. Yet it must not be so strong that the patients are overwhelmed and analysis becomes impossible. In our groups excessive hostility was much less to be feared than the tendency to nip it in the bud. There was one brief interchange of blows, and one chair was smashed. The same patient was involved in both episodes, which occurred when the doctor was not in the room (early in the study we tried seeing what would happen if a group were left completely to itself.) However, hostility did occasionally increase to a degree that prevented analysis of it, as illustrated by the following example:

\*See Situation Analysis 39.

†See Chapter V, pp. 135 f.

In Meeting 89 of Dr. N's Group II Ingram told of his fear that people would use information to incriminate one another and then related a superficial anecdote about telling friends that he could not go fishing with them because he wanted to study when the real reason was that he had no money. He could not admit this because they would use it against him. Bly, who as usual had felt cut out by Ingram, complained that the latter never told anything about himself—which he, Bly, resented. Ingram, obviously overwhelmed by his feelings, flushed deeply. His eyes filled with tears; then he gripped the table hard. Coombs said that Ingram seemed to guard everything he said very carefully. The doctor brought out that Ingram really had talked a lot about himself but spoke in such an impersonal, unemotional way that people didn't notice it. Ingram remained extremely tense and in answer to the doctor's question said that he wanted to punch Bly.

Bly and Ingram stayed after the meeting at the doctor's request. Bly assumed a very patronizing attitude (his typical defense) and admonished Ingram that he would not get anywhere in treatment unless he could speak up more. As Ingram seemed to want to talk, the doctor asked him to stay after Bly left. Ingram said that at first he had wanted to punch Bly but when Coombs had agreed with Bly, his impulse was to go out of the door and never come back. He felt that he could not do anything right and that people didn't want him around. He finally spoke of fantasies of "incriminating" Bly, discrediting him out of his own mouth by telling a person who knew Bly what Bly had said.

All the group members at the next meeting were very apathetic. In the following one Ingram tried unsuccessfully to catch Bly in a contradiction. It was not until the third meeting after the disturbing one that Ingram was able to talk with relative freedom. The episode seemed to retard his therapy for a time. His anger was so intense that it frightened him and impeded his participation. Such examples were rare.\*

The following two examples illustrate how mutual hostility may arise when two patients with similar backgrounds each dealt with a common problem in a way that represented a threat or a challenge to the other. Such feuds sometimes result in therapeutic benefit.

Weber and Trippitt were sons of poor immigrant Jewish parents and were born and brought up in the same city. They had had a slight

\*Situation Analysis 1 shows how the expression of extremely intense hostility was compatible with the therapeutic progress of a number of patients.



acquaintance prior to joining Dr. N's Group 1. They had in common the tendency to express aggression through arguing. They differed in that Weber had made no attempt to secure a better education, having quit after high school to become a printer. Trippitt was studying to become a teacher. Whereas Weber tried to prove that he was smarter than educated people by defeating them in arguments, Trippitt assumed an attitude of intellectual and social superiority. Weber flaunted his Jewishness, Trippitt tended to hide his.

The similarities and differences between these two patients remained relatively hidden until Meeting 39 in which they came to the fore very sharply in a situation bringing out a great deal of mutual hostility, which lasted for ten meetings and which had therapeutic effect not only for these two but for the other members of the group.

The feud was foreshadowed in Meeting 37 when Trippitt said, "I'm greatly embarrassed when I see other Jews do things I wouldn't approve of—when they're not as polite or not as ethical. . . . I feel responsible for the activities of all Jews." Weber rather agreed with this, saying, "I used to feel it more than now." This issue became a rallying topic for the group. The feud came into the open after Coombs attacked Trippitt for his intellectuality and superiority in the next meeting. Weber expressed agreement, saying that Trippitt's intellectuality gave him a feeling of being "under." He did not bring out any other reason for disliking Trippitt until Meeting 39, when Trippitt, in reaction to the group's attack on his intellectuality in Meeting 38, brought out his deep fear of homosexuality. He associated this to his identification with people who make fools of themselves, and then brought out in the same connection his very strong reactions to Jews who incur criticism. Weber then attacked him for his attempt to dissociate himself from Jews and mentioned that he had observed Trippitt's change in accent and behavior when the latter was among Gentiles.

In reply to a comment from another group member Weber said that he preferred to be a member of the Jewish community but had discovered that when he was among Jews he was critical of them. Thus, he expressed the shame previously repressed. In Meeting 40 he raged at Trippitt and his anti-Semitism. "There's something within the race—I've conveyed it to you (the doctor) before—that draws a Jew back into the fold. My inferiority, that I am something to be shunned . . . that you're not welcome to one of your own race (Trippitt). It's like biting the hand of your father." Trippitt replied, "Hasn't that been the thing that kept you working eleven or twelve years in an outfit that hated Jews? You pushed your feelings against Jews into

the background—that creates the feeling you have now.” In the following meeting Weber directed his anger at the doctor (an assimilated Jew). Almost in tears he said, “I came into this room today in a rage. . . . All you need say is that you think therapy has gone far enough . . . , then I might assume you felt the same resentment against me as Trippitt does, and I would lose my identity as a patient and incur your anger as a bad Jew.” The doctor accepted Weber’s hostility as being therapeutically useful. The patient replied, “Your maneuver is planned. . . . Your overfriendly feeling reminds me of my father.” Gradually his tension diminished, and his need to express anger at Trippitt and the doctor (a father surrogate) diminished subsequently, although it did not entirely disappear. During this period his emotional state improved very markedly and he was able to have a candid discussion with his high-strung, overbearing father for the first time in his life.

The feud with Weber made Trippitt realize that the attitude toward being Jewish which he had tried to discuss as an academic question was a deeply emotional one for him. Trippitt began Meeting 40 by saying, “I’ve been unaware how important these religious feelings were in determining actions in my life; strange, I never took them into account.”

The feud continued intermittently until Meeting 48, when it culminated in the most important and lasting therapeutic experience Trippitt had.\* It also led to increased ability on the part of other patients to express hostility and to associate it with their family relationships. Relationships in the group became more emotional and more meaningful. The doctor aimed throughout to get the patients not only to act out their feelings but also to examine them, and he accepted the hostility of Weber and the others when it was turned on him.

Beneficial results also came about from a feud between Coombs and Milton, two Italian Catholics from a poor section of the same city. Coombs was intensely aware of prejudice against his group. Milton, who tended to see the good side of everything and to be unaware of hostility, denied that prejudice existed. They had relatively little to do with each other at first. Milton talked but little, listening to what others said and trying to fit it to himself. He eventually learned that he was afraid of people and that he should try to understand where the fear came from. Coombs, in contrast, expressed his emotions freely.

\*This is described in Situation Analysis 83.

Coombs became angry with the doctor and then with the group when the doctor began to examine with Coombs his escape into fantasy and his failure to get well. Then Coombs suddenly turned on Milton and attacked him for not feeling persecuted as an Italian Catholic. "You don't object at all!" he said. "You've retreated so far you don't realize it bothers you!" When Milton said that he had not felt people beating his head for being Catholic, Coombs aggressively stated that he couldn't understand why Milton hadn't been told by his family of difficulties in getting jobs, etc., because of being Catholic. He became increasingly excited, and the doctor tried to find the cause. Coombs again objected to Milton's not feeling that he was an outcast. Doctor: "Maybe he is spoiling one of your excuses." Coombs: "It seems like an assault on first principles." He realized that he wanted to keep alive his own feeling of being an outcast as an excuse for his lack of success.

The problem reappeared twenty meetings later with Milton in focus. The doctor had taken up with him in private session his constant stress of the good side of people, and Milton had seen that it had to do with attempting to hide his hostility from himself. Despite this apparent agreement with the doctor, Milton asked the group whether it was true that he tended to emphasize the "good side." The way he asked it indicated that he wanted the other members to tell the doctor that it wasn't true. Instead, they told Milton that it was true and that it irritated them. Coombs was more supportive than the others and suggested that Milton was "whistling in the dark." "It seems to me that you have to impute good intentions to others in order to get along." But, as the discussion developed without Milton's changing his position, Coombs became irritated and recalled that Milton did not see prejudice. He contrasted Milton's looking for the silver lining with his own tendency to see evil.

Milton was defensive: "If you are looking for dirt, you can find it." Coombs replied that if Milton had his eyes open, he couldn't help seeing prejudice. The two became quite tense, and the doctor called attention to this. Milton: "It seems that I am aware of prejudice after all." The doctor said that it apparently made Coombs anxious when Milton told him that prejudice didn't exist. Milton: "I realize it's there, but it shouldn't be such a big, whole thing." He brought out that his seeing only the good side was related to his fear of disagreeing with people. Coombs then admitted that prejudice was not as important as he made it. Both continued to show some modification of their attitudes.

In both of the examples cited above the presence of a common experience seemed chiefly valuable in providing a core of mutual understanding, which did not need to be verbalized. It is possible for two such patients to take a lot for granted about each other's feelings and experiences without being in serious error. They may be looking at the same picture but from different vantage points. When they put their points together they get a new perspective on personal problems.

In Situation Analyses 24 and 25 the common background was discovered only after one of two antagonists had brought out certain similarities to the other. The first patient's hostility had arisen early in their acquaintance, partly out of a misconception based on the appearance or manner of the second. In order to mitigate the hostility, the second patient showed a side of himself similar to his antagonist that his appearance had belied. The first patient's discovery of this unsuspected similarity diminished his hostility, making it possible for the second to talk of personal problems. This is, of course, a not uncommon social occurrence and clearly illustrates how hostility may be due to distorted communication.\*

In Situation Analysis 24 the mutual hostility between a passive rebel and a disciplinarian was dissipated when the latter revealed that he too had once been a rebel.

#### *Situation Analysis 24*

##### *DR. N's GROUP II, Meeting 2*

PRESENT: Dupont, Hare, Ingram, Mason, and Thomas

SETTING: Two patients were primarily involved, Hare and Thomas. During Meeting 1 Hare had talked vaguely about himself, making apparent his conflict over parental figures, irritation with bosses, his tendency to plunge into situations and then become confused and back out, and his immature and half-overt rebelliousness. As an only child, coming from a home dominated by his mother until his parents were separated, Hare habitually avoided any consistent pattern and, while he showed no strong hostility to authority, he scorned rules and people who live by them.

\*These two situations are similar to Situation Analyses 31 and 33, in each of which a resistant patient was accepted after his neurotic defense had been broken by a direct attack. They are similar to Situation Analyses 29 and 30 in each of which a patient's resistance diminished after other patients had revealed painful material which the group accepted.



Thomas entered the group at Meeting 2. He was an authoritarian type of person who had tried to conquer his symptoms of headache and anxiety by will power. He had an air of self-reliance and competence and spoke energetically and dogmatically.

An argument between Thomas and Hare began over a government-job situation which another patient had brought up. Hare asked whether Thomas had ever bumped into older disapproving men as he had. Thomas argued at length with Hare about the virtues of discipline and obedience. His tension increased until Dr. N called attention to it. Thomas admitted that he was a disciplinarian and might have been a good storm trooper under Hitler. Hare then talked critically of red tape in government. Thomas asked whether Hare thought people should go their own sweet way. Hare said that he had always bucked his parents, whereupon Thomas commented that Hare was "always bucking someone." He summed up to Hare, "Now, you and I are completely different!"

Dr. N said that he wondered what was going on and pointed out that when Hare had talked of bucking his parents, Thomas had bucked Hare. Hare laughed. Thomas became defensive, saying he was trying to convince Hare of the values of self-discipline. Another patient said Thomas resented anyone who bucked him.

After a brief diversion the doctor brought the focus back to the feud between Hare and Thomas and pointed out that neither of them was very comfortable. They laughed. The doctor then asked what made them uncomfortable.

After Hare and Thomas had argued a little longer and the doctor had suggested again that each man examine how he came by his attitudes, Hare described his trouble as "drifting." He talked vaguely of home, of having no purpose at school, and about the Coast Guard. He told of his parents' being separated, which struck Thomas and which the latter repeated.

**EVENT:** Thomas then told how he had left home at sixteen, having planned a bank robbery. His father could have paid his way through college, but Thomas preferred to be on his own. To show his old man that he was O.K., he made his own rules when he left.

**EFFECTS:** Hare laughed, saying he was sure that Thomas had got all his rules from his family, not on his own. He seemed quite pleased that Thomas had rebelled against his family and commented that Thomas had seemed so smug.

Thomas then said that he would go even further and told of being thrashed every day, although his two sisters had never had any lickings. He talked about his father's finances and occupation, how

he left home, what an inferiority complex he had had at school, and how friendly he had been with his father since he had left home and joined the Coast Guard. He told about his father's religious background, and something about his mother. The meeting ended after a patient observed and the doctor repeated that Thomas had gone back to his father's way of life. Hare left the room hastily.

In Meeting 3 Hare did not attack Thomas, but at one point Thomas said to Hare, "It would be nice if we could always do just what we wanted to."

In Meeting 4 there was no evidence of feuding, and in Meeting 5 it seemed significant that when another patient, who had been feuding with Thomas, was briefly supported by Hare, Thomas immediately pointed out that he had left home and wouldn't take money from his folks, as though to remind Hare that Thomas had been a rebel, which had seemed to make him acceptable to Hare.

DISCUSSION: The distortion with which Hare perceived Thomas early in their acquaintance was seemingly corrected by Thomas' talking about his family background, although one may question whether this was solely responsible for diminishing Hare's hostility. The situation does show, however, how a patient like Hare, who had always passively resisted his parents, became increasingly anxious on meeting a dominating patient whom he identified with his parents. Hare's anxiety was mitigated on learning from Thomas that he had once openly rebelled against his parents. Thomas had acted out a rebellion, which Hare must have long wanted to do, and in this respect the two were similar. Hare's laughter and surprise seemed to express his recognition of this.

Hare's acceptance of Thomas as a rebel and his approval of behavior about which Thomas obviously had conflict seemed to stimulate Thomas to further self-revelations. It brought about a useful rapport between them, making it less necessary for them to try to dominate and fight each other.

In the following situation analysis competitiveness between a passive rebel and an authoritarian patient diminished when an attack by the former led the latter to reveal his own unacceptable background. Self-revelation of the latter was thus facilitated.

### *Situation Analysis 25*

#### **DR. N's GROUP III, Meeting 2**

PRESENT: Akers, Bridges, Cann, Goodfriend, Minor, and Small\*

\*For the psychodynamics of these patients see Chapter iv.

**SETTING:** Of the two central patients Minor was a dapper, successful-appearing, aggressive perfectionistic salesman, with a marked tendency to control, but secretly afraid of his chaotic emotional impulses. Cann had resented wealth and social position since childhood, and deliberately neglected his personal appearance. He repressed his non-conforming and rebellious tendencies but had occasional explosive outbursts of anger.

Minor had taken over the responsibility for the first half of Meeting 1 by questioning another patient. During this period Cann seemed irritated and occasionally also questioned the patient, as if covertly competing with Minor. Later Cann told of his rages at his wife, about which the doctor questioned him. Minor then rather reluctantly told of his own feelings of violence at times and advised Cann that physical activity in the house might be more constructive than beating his wife.

In Meeting 2 both Cann and Minor asked the doctor indirectly for his conclusions about them. When he did not respond, they resumed their hostilely tinged competition. For example, when Dr. N linked another patient to Minor as sharing a similar viewpoint about overcoming difficulties, Cann quickly backed up the doctor by saying that such an approach did not help at all. Later there seemed to be some competitiveness between Minor and Cann over Bridges, a resistant new patient. Cann tried to explain psychosomatic symptoms to him on a rather intellectual level, only tangentially indicating his own problems. Minor finally explained to Bridges what had gone on at the last meeting. The latter responded that it looked to him as though everyone was afraid to talk. This led Cann to talk about some of his personal problems, suggesting finally that he and Minor had something in common. Minor hesitantly agreed and then began to talk more about his traits.

**PRECIPITATING EVENT:** Cann said critically to Minor, "You're a perfectionist." Cann then indirectly showed his interpretation of Minor's well-dressed appearance by asking whether other children had ridiculed Minor as a child for being above them financially—and remarked that Minor had said people in the office were jealous of him.

**EVENT:** Minor, after commenting that Dr. N had given him an idea about jealousy in the office, explained that his financial condition had been just the opposite from what Cann had said. When Minor was a child, the Minor family had been not well off. Although his father had a lot of ability, he could not take responsibility.

**EFFECTS:** Cann was obviously surprised. He said that he and Minor had more in common than he had thought. Cann's tone had changed to one of approval and acceptance.

Minor then continued at some length to tell of how he had helped his brothers and sisters, had tried to see that everything ran smoothly, and had taken on more responsibility than he was capable of handling. He related this to his failures in the service. In a helpful and non-competitive way Cann questioned him. At one point he commented that he hoped he was not delving too deeply. Minor's response was that he was glad Cann had questioned him. Subsequently Cann talked about his irresponsibility and related it to his emotional dependence on his mother.

DISCUSSION: This is another example of one patient's misconception of another early in their acquaintance and its effect on the relationship between them. Cann's antagonism toward Minor was related to a misconception that the latter had come from a wealthy home. Minor's telling Cann that he was poor may well have been motivated by his desire to mitigate this antagonism. Cann then became acceptant, which encouraged Minor to talk about personal problems.

The following situation analysis and examples illustrate how member-to-member hostility may arise out of transference reactions and how bringing these to light is followed by diminishing of tension and therapeutic progress. In Situation Analysis 26 one patient's anger at another diminished when he discovered that the latter represented his mother.

#### *Situation Analysis 26*

##### **DR. N's GROUP III, Meeting 5**

PRESENT: Bridges, Cann, Goodfriend, and Minor

SETTING: The two central patients in this situation were Minor and Bridges. Minor hid his negative feelings toward authority figures and attempted to please them, possibly as a reaction to his need to supplant authority. As the eldest of a large family, he had early taken over responsibility for keeping his parents in line. His anxiety in the group was apparent; he spoke tensely, never allowed a silence, and avoided focus on himself.

Bridges' dominating manner incompletely concealed an underlying mood of helplessness and a poor grip on reality. The latter attitudes evoked from the others, including the doctor and particularly Minor, advice which Bridges consistently rejected or ignored in his fear of dependent relationships. He tried without success to get panaceas from the doctor.

From the outset Dr. N had encouraged patients to examine their relations with others, to watch what happened in the group, and to react freely to feelings about group and extra-group experiences.



During the early sessions there was little expression or recognition of feeling, but an all-around subliminal hostility. One reason for this was that all the patients asked the doctor for directions, but he usually confined himself to observations on what was going on. No patient had openly expressed anger toward another.

**PRECIPITATING EVENTS:** Bridges invited advice and rejected it. The doctor made observations on the group's fear of expressing feelings and on Minor's seeming to be blocked and tense. In Meeting 5 Bridges continued steadfastly to resist advice despite his helpless air. He took over early with considerable pressure of speech, complaining circumstantially to the doctor about his drinking, his feelings of pressure about trivia, his discouragement about his condition, his basic feeling that he appeared worthless in the eyes of others, and his ability to play many roles. The doctor was relatively silent. Bridges consistently rejected sharp comments from Minor and advice from other patients. In regard to Bridges' impersonations, Minor said forcefully, "Maybe you're trying to get away from yourself." Bridges ignored this. Minor argued that Bridges was using "too much energy." When Bridges later denied that he wanted riches or power, Minor said firmly that he did not believe Bridges and agreed with another patient that Bridges was aiming too high. Bridges denied this but admitted that he did not know where he was going. Minor replied, "You've got to set your goal." Minor seemed to be becoming increasingly irritated.

When Cann remarked that he also was an actor like Bridges, Minor said accusingly that Cann and Bridges were living "in a dream world." When Bridges denied this, Minor referred to his impersonating others. Bridges said he did this just for "a change of pattern" and asked what was wrong with that. Minor, sitting forward in his chair, insisted heatedly, "That's not being realistic—not yourself—it's impossible for you to recognize your true personality." Bridges replied at some length that he could go for a day or a year without anyone's discovering his true self. Minor looked ready to interpose objections, but Bridges went right on. When the doctor remarked that Minor was least able to get the floor today, Minor replied irritably that he was closest to the truth but others didn't want to hear him. The doctor observed, "There is a lot of tension in Mr. Minor today."

**EVENT:** Minor then suddenly blurted out that his mother was always acting in a dream world. She was always trying to impress others. She had a million impersonations. She lost her personality in playing others. He always told her to face reality. Dr. N: "Just what you told Mr. Bridges." Minor: "Yeah." He sat back in his chair. Bridges repeated that Minor was really talking to his mother in talking to him.

Minor remained silent. Dr. N observed that the impression we get of others depends on whom they remind us of. Bridges, Cann, and Dr. N all talked at some length about the value of watching oneself in the group and seeing one's sore spots.

EFFECTS: For the rest of the meeting Minor seemed more relaxed, speaking less often, more softly, and with less pressure. First he reinforced, with the doctor's help, his recent feelings about not being responsible for or able to change his mother. He observed that he had been trying to straighten Bridges out but that maybe he couldn't, because he didn't have Bridges' answer. Dr. N: "Or your mother's." Minor said he had given that up, he thought, and described his sister's calling to say that his mother was upset again and his replying that he could not remedy anything there and had given up trying to. Later, Minor broke into a pause in a discussion between Cann and the doctor, with the question: "What will come of this (his new understanding of relations with Bridges)?" Dr. N said that the next time someone outside upset him, Minor might think of which feelings were appropriate and which were not. Minor then said musingly that if he had gone on, he would have made Bridges angry.

Cann and Bridges spoke more freely than before about their feelings. Bridges discussed with real concern his worry about drink and having a complete breakdown. Cann talked of his rages with his wife and for the first time mentioned his worries about the possibility of being hospitalized. Minor did not offer his usual advice to Cann about his hostility toward his wife.

These effects seemed to be sustained in later meetings. Minor showed a continued awareness of his need to re-examine his relationship with Bridges. He no longer attempted to conceal his diminishing irritation toward Bridges. At Meeting 7 Minor associated his own background with Bridges' relations with his inadequate father. When Minor openly expressed his dislike for Bridges, he attributed it to the fact that he recognized in Bridges mechanisms of his own, such as setting his goals too high. Bridges' attitude to Minor showed less tension, more acceptance, and almost a trace of dependence, perhaps made possible because Minor's hostility to him had been explained away as not personally relevant to him.

DISCUSSION: In this situation Minor's hostility to Bridges was based on his identification of the latter with his mother because they had in common attitudes irritating to Minor. Bridges' irresponsibility may also have been disturbing to Minor because he feared this in himself and had kept it under control with difficulty. This was shown later by his intense self-disgust over gambling bouts and his fantasies of desert-

ing his wife and family. The doctor facilitated a therapeutic resolution of the hostility when he supported Minor by showing awareness of Minor's distress and tacitly encouraging him to look for its source. This he did by calling attention to his tension, implying that it was excessive for the immediate situation. When Minor achieved some insight the doctor continued to support him by comments on its value, which others seconded. This helped Minor to continue his self-scrutiny and his success encouraged the others to do the same.

### *Other Examples*

The following example illustrates how the doctor by focusing on the precise feelings of one of the antagonists led him to see more clearly the transference aspects of his behavior.

Before joining Dr. Z's Group Phillips had said in an individual session that he hesitated to join a therapy group because he thought that telling others about himself gave them an advantage over him. This had led to the discovery that he was suspicious of others' interest in him and regarded as friends only those who had shown themselves to be more neurotic than he and who were at a disadvantage on his terms. He had an older brother whose material success he envied and whom he grudgingly admired. He competed with his brother by trying to show that he was more understanding of their mother and more charitable toward the younger siblings. This was the pattern of his campaign against Kootch.

Kootch appeared to be in control of situations and was contemptuous of those who "let their hair down." When the group isolated him because of this attitude, he explained that he could not act otherwise because he could not bear to be a weakling like his idealistic father. Kootch admitted that while he admired the realist, the go-getter who made money, he was unfortunately an idealist.

In Meeting 13, Phillips' first, a hostile situation promptly developed between him and Kootch around talk about "ideal parents." When Phillips attempted to qualify and contradict Kootch's remarks, the latter tried to exclude him from the discussion by referring to material from earlier sessions.

The same pattern continued in Meeting 14.

In Meeting 15 Phillips agreed with another patient who expressed resentment of the go-getter and then accused Kootch of resenting him and of not really listening to what he said. Kootch: "A lot of people feel that way about me." Phillips then accused himself of arousing resentment in Kootch by "talking to him in the role of teacher to

pupil" and of "being too superior about it." Dr. Z pointed out that these were significant attitudes and asked Phillips about similar situations. He replied that he was often irritated by his brother's habit of putting him off in a superior way: "Nobody likes advice-giving." Dr. Z commented, "You talked to Kootch as your brother talked to you—then you felt Kootch was resentful." Phillips agreed and the doctor continued, "I wonder why you approached him that way." Phillips answered, "There is a lot of relief in letting off steam that way." He then told other ways in which he copied his brother.

This was followed by more comfortable relations in the group. At the next meeting a patient said, "It's easier to talk in the group when we come without our dress shirts—we feel more relaxed," and Phillips agreed, posing the question, "Why can't we talk to others on the outside this way?" Later when he said that he had learned a lesson—"Do the work instead of crying about it"—Kootch, his former rival, remarked, "That is my character too."

The doctor concentrated on Phillips' attitude rather than Kootch's because Phillips gave him a lead, and had the support of another group member who also expressed resentment of go-getters. Kootch seemed to need his "front." Premature analysis of their defenses might have driven such patients from the group.

The following example illustrates how two patients who had been carrying on a persistent feud realized that strong positive as well as negative feelings were involved when they were able to examine their relationship after about a year of treatment.

In the early meetings of Dr. K's Group Mercer had been relatively quiet when Turner's intellectualism and previous psychiatric treatment had made him the dominant patient. As the group gave increased approval for self-revelation, Mercer slowly came to attract attention through his capacity for free association to any topic and his apparently successful working through of problems. The doctor and members were much impressed by his behavior, except for Turner, who maintained that Mercer's success was "phony." At first there were strong indications that the basis for Turner's attitude was rivalry for the doctor's attention. In Meeting 26, for example, he said, "I felt sort of left out because you were showing him (Mercer) off."

In Meeting 28 Turner again attacked Mercer's position, recalling that two weeks earlier Dr. K had shown him off as a "prize student." Mercer answered, "I remember that you were peeved and that you peeved me by saying that." Turner: "I didn't believe what you said. I frequently don't. I feel you are so anxious to get into the game that



you may be insincere." Mercer: "I doubt my sincerity too." Turner: "I don't know why it bothers me. Maybe it was the limelight. Maybe it was the affection of the doctor."

The two men soon found that they had a more specific meaning to each other. Mercer reported that he was "always putting on a show for Turner . . . to get a rise out of him . . . to put him on the defensive." Turner resented Mercer's "playing ventriloquist" for the doctor.

Turner's transference to Mercer of his relations with his brother became evident in Meeting 36. When Mercer expressed fear of insanity, Turner asked whether Mercer had told his mother of these feelings. Turner then said that his own brother's strange behavior made people talk, "which was just what he wanted." Mercer: "That's how he got satisfaction." Turner: "Sure, and I've always told my mother that, too." (This description of Turner's was clearly directed at Mercer's role with regard to the doctor.) Turner continued to produce examples of how some other younger male in his family, who was a successful "attention getter," was like Mercer.

At Meeting 58 Mercer said that Turner was like Mercer's mother, "in his capacity for darting out" at him. Turner wondered why he had to "handle" Mercer. Mercer went on to describe his own mother as "martyrlike," touching on an area that Turner had defined as "his exquisite sensitivity." (Turner's mother was a bedridden "martyr," but a strong parent, while Mercer's mother was a martyr who represented a constant "frustration.") Both Turner and Mercer grew angry but could not express their hostility.

At Meeting 60 Mercer was concerned with his "warm feelings" for men, which he felt were homosexual. Turner: "In whose eyes?" Mercer: "I couldn't even smile at you (Turner)." Turner then related the story of a girl who was afraid of being a Lesbian because she had been told she was and believed it. He stressed the analogy by saying that Mercer was afraid that another patient would misinterpret the smile. Mercer told of wanting to smile and fighting it down. He finally smiled and said he now felt warmer toward Turner and more at ease, but it embarrassed him. Mercer told about "palling around" with athletic fellows toward whom he felt warmly and with whom he was not ill-at-ease. Dr. K asked what Mercer thought of in connection with warmth. Mercer said, "Mother, breasts, bed, warm. . . . This room is warm." Mercer then suggested that Turner was a warm person and said tentatively, "If I become warm to you and put my defenses down. . . ." Turner rebuffed him by remarking that Mercer had said a little earlier that he had no defenses, and Mercer concluded his sentence by saying, "He would push me away." Turner asked,

"So what?" Mercer said that he resented what had gone on in general and Turner in particular. Turner said, "It sounds like the story of your father. You are conscious of love for your father, which was a surprise to me. If the feeling toward your father was bitter, then you might fear that another relationship might turn out like the one with your father." (Mercer had described his father as not allowing anyone to touch him, not even his children, whom he kept at a distance.) Mercer said that he rebelled at that idea, then admitted that Turner might be like his father to him and later suggested that he might be like his mother, concluding that Turner reminded him of someone in authority. A few minutes later Dr. K said he thought that Mercer sought a father figure, and Turner a son. He said that he brought these things up to show that they were not dangerous—"You don't destroy him (by your behavior)." This permitted Mercer to describe his feelings toward his father: "Warm one minute, like kissing and hugging, and the next minute I want to kill him." The doctor later suggested that Turner was trying to "repress some feelings." Turner said that Mercer reminded him of his nephew, who was twelve or thirteen years younger, and he assumed that there was affection between them. Mercer and Turner agreed that Mercer's feelings were warm, but Turner said, "If I felt warm feelings, I would be as afraid as you are."

The relationship between the two never showed the strongly friendly aspects revealed in the individual sessions of each, and even there they did not seem to have been thoroughly worked out.

The course of the rivalry and feuds between these two men suggests that their hostility was due to the fact that each transferred to the other the characteristics of a significant person in his life and then reacted as if the other were that person. In Turner's case Mercer represented his more successful younger male relatives; in Mercer's case Turner represented the authoritative aspects of his parents. In reality the resemblances to those persons was quite close. Progress in therapy was made, as would be expected, as the transference situations were analyzed.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

Group therapy more easily elicits a wider range of emotions than individual therapy because there are more persons to whom the patients react. Hostility between patients can frequently be turned to therapeutic use. We have observed that patients may be hostile toward each other:

1. If one patient has characteristics in reality similar to another patient toward whom the former is negative or ambivalent, although the similar characteristic may be minor and the affective reaction exaggerated.
2. If one patient talks about or acts out an attitude or feeling that another has repressed or suppressed.
3. If they have different defenses for a common problem.

Doubtless there are causes other than these for feuds between patients. In most persistent feuds based on transference reactions, it should be possible eventually to uncover and study hidden positive feelings; it may also be presumed that these are present when transference patterns are involved, since the latter reflect the ambivalent emotions of childhood.

As in any therapy involving catharsis, the reactions must be allowed to continue until the patient has expressed enough of his feelings to permit him to try to understand them. The reactions may recur many times until the difficulty is worked out.

If the dynamics are understood by the doctor, it is not usually necessary for him to "give insight." A properly timed question about what is going on, or a suggestion in regard to projections and displacements, will usually induce one of the feuding patients to associate to the situation. Since mutual hostility often involves an attempt to dominate the group, it is important for the doctor to maintain his objectivity and to indicate his acceptance of both antagonists.

These reactions are important to therapy because of the negative and positive potentialities. Perceptual distortions that arouse hostility prevent communication between the feuding patients, with the result that the negative affect is further exaggerated. When the distortions are understood, not only may this insight be therapeutic, but usually the discovery of a common background or common problems makes for a good working relationship after the difficulty is resolved. Other patients with similar problems or mechanisms may become involved in the discussion in a way useful to them, although sometimes a considerable interval elapses before they participate actively. They may discuss their own relevant problems or support one of the antagonists, or they may serve as buffers or divert the discussion if the tension gets

too great. It is helpful for the doctor to keep in mind the therapeutic potentialities of these reactions.

Anger out of all proportion to the occasion may become a barrier to communication. So much anxiety may be aroused in the angry patient and others that therapy comes to a stalemate. This barrier tends to perpetuate or increase the distortions. Under such circumstances lack of anxiety on the part of the doctor or one of the patients may have a steadying effect on the group; it thus facilitates the resumption of communication and usually helps the angry patient to be less afraid of his own anger.

While analagous problems arise in individual therapy and the mechanisms of therapy are practically the same, it would appear that resolution is facilitated by the group, in part, perhaps, because the doctor can maintain his objectivity more easily when he is not the object of the distortion causing the hostility or at least is not the sole object.



## CHAPTER XI

### *Forms of Resistance and Their Resolution*

---

THIS chapter deals with some of the methods by which various kinds of resistance may be overcome by the group but which are not possible in individual sessions. It should be stressed, however, that the examples given represent only a beginning in the understanding of this central problem of therapy. We have singled out three patterns of resistance—as represented by withdrawn patients, openly antagonistic patients, and a patient whose subtle resistance took the form of intellectual rationalizations. Members of the group dealt with these resistant patients in three general ways.

A resistant patient may participate at first as an ally or protégé of a patient in whom he perceives a similarity. Again, a resistant patient may follow the lead of a patient who has expressed problems similar to his without being rejected. Finally, a resistant patient may be won over by the suggestion that his underlying feelings would be more acceptable than his defenses. We have also included a discussion of silence on the part of the entire group.

#### RESISTANCE OF INDIVIDUAL PATIENTS

In the following situation analysis a withdrawn, distrustful patient interacted spontaneously for the first time as the protégé of a patient with similar attitudes but a more aggressive manner.

#### *Situation Analysis 27*

DR. Z's GROUP, *Meeting 1*

PRESENT: Giordano, Olem, Reiser, and Stafford

SETTING: The central patients were Olem, a distrustful man who kept silent for fear of disapproval and depended on achievement for

self-confidence, and Reiser, who was also distrustful but aggressively self-defensive. Both resisted therapy. The other patients, Stafford and Giordano, were aggressive and seemed to try to please the doctor.

At the start of the meeting Reiser had suspiciously questioned the purpose of the microphone; whereupon Giordano, saying, "We've got to feel free to talk out here," had hurriedly initiated a series of questions about marriage and sex, shyness, and hospitalization, which he seemed to think the doctor might want the group to talk about. Reiser had again, and rather hostilely, questioned the purpose of the microphone, and Giordano had suggested Reiser's probable lack of trust in anyone. Stafford participated in discussions frequently but tangentially.

Almost midway through the meeting, when Giordano, Reiser, and Stafford were talking about their hospitalization and depressions, Dr. Z had asked, "How about you, Olem?" Olem replied that in childhood he had some trouble. Giordano asked whether Olem's stomach ever tightened up. Olem responded briefly, vaguely, and almost inaudibly. Dr. Z: "Most of these things started way back." Olem remained silent.

EVENT: After telling a success story about his rise vocationally through the help of an old friend, Reiser commented, "Well, you see, here we have four people and four different types of shyness." In kindly fashion, Reiser had included Olem in the group. A minute or two later, in response to Dr. Z's own open question—"Anybody else want to go into that?"—Olem emerged with a barely audible difference of opinion with Giordano. Attacked by Stafford, Olem was quickly protected by Reiser and encouraged to say what he thought when Reiser said paternally to Olem, "Why don't you make a little experiment here?" (i.e., about talking).

EFFECTS: After a few mumbling comments Olem clearly disagreed with Giordano, looking at Reiser as he spoke. Giordano contended that Olem was wrong, claiming that the latter's feelings had been repressed so long he didn't realize he wanted the center of attention like everyone else. Olem repeated his disagreement; he didn't want the spotlight, he just wanted to be on equal footing. In a soft voice Reiser responded to Olem, "I can see that." When Giordano stated that he wanted the center of the stage here too, Reiser spoke up loudly to Giordano, saying he could see that Giordano was a battler and that Giordano gave people a rough time.

Reiser told Giordano that he wanted the whole pie, whereas—turning to Olem and asking, "What's your name?" and getting the response "Bob"—Reiser said, "Bob, I think it's more important we get what we feel we deserve."

During the remainder of the meeting Olem participated occasionally with Reiser's support. For example, when Reiser asked Stafford what he did, and Stafford said that he was going to school, Olem came out spontaneously with the information he was taking drafting but didn't like it and wanted to design buildings. Stafford tried to point out the need for drafting. Reiser advised Olem, "You can't run before you can walk," and then asked about Olem's marks. Olem said that they were poor and that he wasn't interested.

At Meeting 2, from which Olem was absent, the first patient to comment was Reiser, who commented on Olem's absence: "We are shy a customer. What happened to Bob?" In Meeting 3, Olem reminisced, "I felt good when Reiser asked me some questions (in Meeting 1) and felt hurt and resentful at Giordano for not agreeing."

DISCUSSION: Neither the doctor's nor Giordano's questions provoked any significant response in Olem. Giordano, who echoed the doctor's feelings and focused on content which the doctor might be considered to approve, was not acceptable to Olem for an initial relationship. As a matter of fact, Olem opened by differing with Giordano and made no spontaneous comments until after Reiser had made comments that specifically included Olem in the group. Olem seemed able to speak because of the attention of another patient, who was especially solicitous of him but was aggressively distrustful of the doctor. Apparently it was also important that the doctor permit Reiser to show interest in Olem at this first meeting without questioning it.

TENTATIVE DEDUCTIONS: In this situation a withdrawn, resentful, distrustful, and dependent patient who could not be drawn out by the doctor or a patient whom he identified with the doctor, was enabled to express some of his feelings under the kindly encouragement of a patient who was also resistant and suspicious but was aggressively verbal about it. This may have been facilitated by the doctor's permissiveness.

In the following situation analysis, a withdrawn, hostile patient, avoiding the doctor, responded somewhat under the initiative and protection of an overtly hostile patient whose problems were similar to his own.

### *Situation Analysis 28*

#### *DR. N's GROUP II, Meeting 2*

PRESENT: Dupont, Hare, Ingram, Mason, and Thomas

SETTING: At the first meeting of the group, at which nine patients were present,\* Ingram, a very shy, distrustful student, who believed

\*See the running account in Appendix A.

in discipline and who greatly feared others' disapproval, did not speak until almost midway through the meeting. Then he generalized and spoke briefly and vaguely, like a good boy, apparently because the doctor wanted him to speak. His responses to the doctor's direct questions were always very brief.

At this second meeting Thomas was present for the first time. He was a squat, positive little man, fitting the stereotype of a tough first mate. For the first fifteen minutes Ingram remained silent. To Dr. N's question, "Want to bring up something, Mr. Ingram?" Ingram replied, "No, just thinking." Then he asked the doctor whether his "subconscious mind" could affect his (stiff) leg. The doctor said it could, amplified this, and then asked if Ingram had any notion as to why he was tense. Ingram shyly said, "No," that he just "woke up that way." Ingram remained silent for the next half hour, during which Thomas began and got deeper and deeper into a feud with Hare, the non-conformist.\*

EVENT: After Thomas had attacked Hare vigorously for not believing in discipline but thinking that "people should go their own sweet way," Ingram briefly defended the service and then, echoing Thomas' comment to Hare, asked Hare hesitantly whether he considered himself too well qualified for K. P. or mess work in the service.

EFFECTS: When Thomas talked of dreaming of a Jap and a bayonet, Ingram indicated a similar experience. Hare asked about jerking in his sleep and Ingram again added his experiences. Ingram seemed now to be talking more freely, but a few minutes later, Ingram silently shook his head in response to a direct question from the doctor.

Then Thomas became quite protective of Ingram in his continued offensive against Hare, saying that Ingram wouldn't talk because he was afraid he would be cut off (the implication was, by Hare). Thomas then asked Ingram, "Do you believe what I said about discipline?" and Ingram replied that he did. Later, Thomas said that discipline was an evil but less of an evil than what might appear without discipline. Spontaneously Ingram again spoke up for Thomas and shortly thereafter asked Hare quite directly whether he felt strongly about *anything*.

DISCUSSION: Ingram, a withdrawn, very suspicious man, resisted the efforts of the doctor but joined the discussion as an ally of a patient whose attitudes, expressed to a third patient, were so similar to his own as to imply approval, which was later directly expressed.

Situation Analyses 27 and 28 are summarized in Table 11.

\*See Situation Analysis 24.



TABLE 11. Resistant Patients Who Participated as Protégés of  
Group Members in Whom They Perceived Similarities

	<i>Dr. Z's Group, Meeting 1</i> <i>Situation Analysis 27</i>
SETTING <i>Doctor</i>	Moderately active, permissive.
<i>Group</i>	Competitive.
<i>Resistant patient</i>	Olem: reticent, hostile, silent through fear of disapproval; looked to achievement for self-confidence.
<i>Patient to whom he related</i>	Reiser: overtly hostile.
EVENT	Reiser encouraged Olem to speak and attacked his attacker.
EFFECTS	Olem strongly differed with his attacker; subsequently revealed uncertainties about vocation.

*Dr. N's Group II, Meeting 2*  
*Situation Analysis 28*

COMMON FACTORS

Active but not very supportive.

Active.

Uneasy.

Tense.

Ingram: shy, withdrawn, secretly hostile; deeply distrusted others and feared their opinion; believed in discipline; silent through fear of disapproval; seeking to gain self-esteem through college degree.

Hostile, silent through fear of disapproval; based self-confidence on achievement.

Thomas: dominating, aggressive disciplinarian.

Resembled resistant patient but aggressive.

Thomas attacked another patient for not believing in discipline.

Approval of resistant patient indicated directly or indirectly.

Ingram participated with increasing freedom under Thomas' continuing lead.

Eventual participation of resistant patient.

In the following situation analysis an ambivalent patient talked about himself after demonstration by other patients, one of them like himself, rather than in response to the doctor's questions.

### *Situation Analysis 29*

#### **DR. N's GROUP III, Meeting 2\***

**PRESENT:** Akers, Bridges, Cann, Goodfriend, Minor, and Small

**SETTING:** Bridges and Small were new to the group at Meeting 2. Small was a slight, withdrawn patient. Bridges, a salesman, was a heavy man, with a booming voice and a rather positive and challenging way of speaking. Underneath this was an ambivalence about expressing his dependency needs and revealing personal weaknesses. His attitude was, "I've got to be shown that this (psychotherapy) works." Like Bridges, Minor was a salesman, verbally aggressive and with an imposing but fragile front.

The meeting opened with Cann and Minor questioning the doctor about the conclusions he had come to about them as a result of the previous meeting. The doctor reviewed the process of the last meeting, but Cann seemed disappointed with the lack of "answers." Dr. N said finally, "The doctor's telling you is not going to help a bit." This rebuff and refusal to meet the patients on their own terms seemed to send the group off on tangents. Goodfriend became platitudinous and advised repression. Cann argued with him mildly. Small suggested that a million dollars would help. Goodfriend brought up a poor man's ability to go fishing, even if he hasn't any money.

Bridges' entering and challenging comment was to object that fishing was a form of relaxation for just a short period of time. Minor argued with Bridges about this, maintaining that a vacation might give a person courage to face his problems. Bridges, changing the subject, asked whether the six patients present all had the same symptoms, and Minor explained that two of them had found their main difficulties quite similar.

Bridges then kept asking Dr. N in a challenging way what the group ought to do and asking the patients to tell a little bit about themselves. Dr. N pointed to the conflict between Bridges' assumption of responsibility for the group situation and his request that the doctor take such responsibility. Bridges became defensive and then asked the others to talk about their problems, maintaining that he had none—except physically and emotionally. Dr. N thought that perhaps Bridges could tell the group about this.

\*See Situation Analysis 2 for Meeting 1 of this group. For the psychodynamics of its members see Chapter IV.

Bridges replied that there was nothing to tell other than what he had just said. He switched the focus to Minor, asking whether he had a problem today that he could not solve, since he had started talking about how vacations might help with one's problems. Minor did not directly take up this challenge but, with Cann's help, continued to discuss vacations and symptoms with Bridges. Intermittently, Bridges went on asking the doctor questions.

After further discussion about symptoms and what should be done in the group, Minor said that each one had voluntarily discussed his own problem and referred back to the first meeting. Bridges said, "It looks to me like everybody's afraid to talk."

EVENT: Cann said that he would start off then by describing his diarrhea on release from service, his temper tantrums, and fighting with his wife. He pointed out that his difficulty and Minor's were quite similar.

Minor then talked in some detail about his family, his being a perfectionist, his taking responsibility for his family's welfare. Cann, Goodfriend, and Bridges participated in the focus on Minor. When Cann asked whether he had been delving too deeply at one point, Minor replied, "No, I'm rather glad you did—just for Mr. Bridges' sake. Now right there, I think I found one reason that. . . ." Here Minor revealed a new insight into the extreme concern he felt when things seem to be running smoothly.

EFFECTS: A minute later Bridges said, ". . . Now I'm willing to bare all mine (problems) and be stopped and to have anybody interrupt, but that would run into hours, days, and weeks. . . . I think he (Minor) has been helped a little, but how long, how deep, how far back? . . . If we get right to one point, possibly we'll help each other, maybe not."

Cann explained to Bridges that according to the way the group had been working, one person couldn't tell his whole story at once. Bridges said that that was just what he had said. Cann continued that one had to have the confidence of the rest of the group. Bridges: "But where do we start?" Dr. N: "Haven't we started?"

Bridges agreed that they had and began, "Actually, he (Minor) started on his recent experiences. Perhaps I ought to give my recent experiences. I've talked to the doctor, and one immediate problem. . . ." Bridges then went on about his domestic situation and his difficulty in regard to assuming responsibility. He remained in focus for about twenty minutes as Cann, Dr. N, Small, and Minor in turn commented or questioned him helpfully.

DISCUSSION: Bridges, who was ambivalent about his dependency,



had a "show me that it helps" attitude about therapy, expressed as a challenge to the doctor and to the group. Dr. N's attempts to get him to discuss his problems had no effect. These consisted of saying that the doctor could not help by giving answers and then trying to put Bridges in focus by calling attention to his behavior in the group or directly questioning him and inviting him to speak.

The doctor's early rebuffs to Cann's and Minor's direct requests for information seemed to turn them to each other for help. Their uncertainty about therapy may have been heightened by Bridges' challenges. They met their own doubts by putting on a demonstration for him which showed both the process and the beneficial effects of therapy. Their ability to reveal their own weaknesses without loss of approval seemed to help Bridges to express his own difficulties.

It is interesting that Minor, the patient who reacted most strongly to Bridges and whom Bridges followed, was also a verbally aggressive patient and a salesman with an imposing but fragile front.

**TENTATIVE DEDUCTION:** In this situation a new patient who was ambivalent to therapy and whom the doctor could not reach was enabled to show weaknesses when he saw another patient similar to himself do so with implied approval and therapeutic benefit.

In the following situation analysis a resistive, competitive, and isolated patient became self-revealing when an opponent supported him and revealed himself.

### *Situation Analysis 30*

#### **DR. K's GROUP, Meeting 2**

**PRESENT:** Turner, Steele, Hammond, and Boyden

**SETTING:** This was a highly competitive group in which the doctor was non-participant.\* The central patient, Steele, was a stutterer, obsessive and hostile to the doctor. He relied on intellectual superiority for his self-esteem and sought to control the group by logical argument. Hammond and Turner were also very competitive and sought to impress and dominate by a show of intellectual superiority. In sharp contrast, Boyden minimized his intelligence, was non-competitive, and talked readily about himself in response to questions from other patients. Steele had a protective attitude toward him.

At the second meeting Steele opened the discussion in a way that was hostile and challenging to the doctor. Referring to Dr. K's remark

\*See Chapter v, pp. 122 ff.

in an individual session that he planned to enlarge the group, he asked whether untrained people here in the group could do harm. Turner explained contemptuously to Steele, "I'm trying to say I don't think much of the idea." Hammond asked Steele, "Have you experienced any such reaction concerning this since last time?" Steele, defiantly: "I'm not bringing this down to specific cases." He then defended with increasing stuttering his being abstract, while Turner argued that it was a defense. In response to further arguments from Hammond, Steele shifted back to his concern with Dr. K's intent to enlarge the group. When Steele asked Boyden for his opinion, the latter expressed agreement with the rest of the group.

**EVENT:** The group stopped belittling Steele and talked about their personal problems and what they hoped to gain by doing so. Hammond, as if in support of Steele's doubts, said his own difficulty was a panic that seized him among strangers. Turner: "Isn't the fear of exposure something that we can get away from in this sort of a group?" Steele asked for Boyden's view. Boyden: "To be able to tell more would give relief from shame."

**EFFECTS:** Steele replied to Boyden and the group, "That agrees with Mr. Turner's point; this has helped me. I get nervous in groups. . . . Last time you gave me a feeling of success." After participating in questioning Hammond, Steele gave a summary of his history and problems. When Hammond asked what he did for sexual outlet, Steele answered in some detail, mentioning his lack of success with women and his masturbation.

**DISCUSSION:** It was apparent that Steele had become uncomfortably stranded in a competitive situation in which his need to dominate prevented him from giving up his isolation. To bridge the gap he sought the opinion of a member who shared the views of his antagonists but whose lack of competitiveness made it possible for Steele to accept his opinion without appearing to give in. The other patients stopped attacking him and talked about their own problems. As a result Steele gave up his defensiveness and could then discuss problems similar to theirs.

Situation Analyses 29 and 30 are summarized in Table 12 along with two similar situations.

In the following situation analysis a patient's resistance was overcome when another criticized his defenses, but the group gave him support in discussing his underlying problem.

TABLE 12. Resistant Patients Who Followed the Lead of Group Members Expressing Similar Problems

	<i>Dr. N's Group II, Meeting 4 Situation Analysis D*</i>	<i>Dr. N's Group III, Meeting 1 Situation Analysis 2†</i>
SETTING		
<i>Doctor</i>	Active and acceptant.	Inactive, permissive.
<i>Group</i>	Inspirational atmosphere.	Permissive.
<i>Resistant patient</i>	Castell: withdrawn paranoid; silent through fear of disapproval; sculptor, ex-actor; relied on artistic performance for self-esteem; Greek.	Goodfriend: reticent, hostile, distrustful; silent through fear of disapproval; relied on will power and performance as mechanic.
<i>Patient to whom he related</i>	Gerber: kindly manner; musician; Greek.	Akers: revealed weakness; acceptant of others in group; plumber.
EVENT	Gerber talked about his stage fright.	Akers implied critical feelings toward boss.
EFFECTS	Castell spontaneously expressed sympathy for Gerber. Acknowledged similar feelings. At next meeting talked a little about himself.	Goodfriend showed similar critical feelings about bosses; advised in area of his competence.

\*S. A. D does not appear in text.

†See Chapter v, pp. 125 ff.

*Dr. N's Group III, Meeting 2*  
*Situation Analysis 29*

Moderately active, non-acceptant.

Competitive.

Bridges: in conflict over dependency and need to dominate; resisted revealing weakness by questioning others; relied on independent success for self-esteem; salesman.

Minor: self-revealing, hostile, but compliant toward doctor; salesman.

Minor revealed personal problems under Cann's stimulus, especially his feeling of responsibility for family.

Bridges talked about his own conflicts in regard to family responsibility.

*Dr. K's Group, Meeting 2*  
*Situation Analysis 30*

Non-participant.

All discussed personal problems except Steele; all intellectually competitive except Boyden.

Steele: defended his reticence against others' attacks but was unhappy in his isolation; competed for dominant position by intellectualizing; relied on intellectual achievement for self-esteem.

Boyden: discussed his problems but did not compete with Steele, who protected him.

Group stopped opposing Steele, discussed personal problems and value of doing so. Boyden concurred.

Steele talked about his sexual problems and other intimate matters.

COMMON FACTORS

Various, not a determinant.

Various, not a determinant.

Reticent out of fear of disapproval or of revealing weakness; based self-esteem on performance.

Perceived as similar or not threatening by resistant patient.

Personal problem or weakness similar to that of resistant patient brought out.

Resistant patient followed lead of patient to whom he related.



*Situation Analysis 31***DR. N'S GROUP III, Meeting 2**

**PRESENT:** Akers, Bridges, Cann, Goodfriend, Minor, and Small\*

**SETTING:** In the earlier part of this meeting, when two patients were challenging the doctor, Goodfriend interrupted to talk vaguely in generalizations about feelings of persecution. In the course of subsequent discussion he occasionally spoke abruptly and briefly in platitudes, which he usually prefaced with "Excuse me for interrupting." Bridges had become anxious in the course of a long discussion with Cann about their conflicts over responsibility.

When Cann was in focus, Goodfriend advised him, "Just don't worry about responsibility for yourself and your wife and go ahead and do what you have to do." Cann said, "Sure I know that, but you just have to make a living." Goodfriend then advised counting all the obstacles to be overcome and how to do it. He added, "Actually, there's nothing that's impossible—except getting off this earth. . . . You're a prisoner here, born here and die here." Cann responded to Goodfriend.

**EVENT:** Bridges interrupted Cann and turned to Goodfriend, saying, "I wonder why you always think that someone's fighting you?" Goodfriend: "Who, me?"

**EFFECTS:** Goodfriend then explained that he had developed complexes because it always seemed to him as a kid that the other kids were throwing stones at him. "You see, I'm Jewish. I've always felt someone was after me." Bridges asked whether Goodfriend had ever been beaten up, and Goodfriend said, "No." Bridges remarked that Goodfriend always talked of fists. Goodfriend replied that life is a fight and that one must have strength of mind and body to fight. Bridges gruffly asked Goodfriend where he had learned that and continued, "You say you're Jewish. Why do you feel bad about it? Do you feel you're inferior?" Goodfriend said, "No." Small said he thought that Goodfriend's remark about being Jewish was no explanation. Goodfriend then reviewed how in the service it was real; he told about a Jewish officer, "how the fellows pulled out the propaganda stuff . . . the hate program," and how he felt that he was "lost" like a child wandering around. Bridges then talked at length about a Jewish officer who had been one of the best men in his outfit.

Cann said he thought that such remarks were simply soft-soaping

\*For the psychodynamics of Goodfriend and the other patients see Chapter iv. For Goodfriend's behavior in Meeting 1 of this group and the doctor's technique see Situation Analysis 2.

things and told in detail about what he saw as anti-Jewish prejudice in this country. In the course of the subsequent discussion Minor complimented Goodfriend on his analytical mind. Goodfriend then told more about anti-Semitism in the service, and Minor stated that the Irish had laughed away their religious persecution. Small paid a long tribute to a Jewish officer in his outfit. Bridges generalized on how minorities were always persecuted. As the meeting closed, the doctor asked why all the patients had felt it necessary to reassure Mr. Goodfriend about his being Jewish.

Immediately Goodfriend asked, "Any of you fellows feel you are tense at times, as though things are hitting home (in the group)?" Akers and some of the other patients echoed, "Certainly." Goodfriend: "As though you were up against a wall?" Bridges concurred, "Like a boil coming to a head."

At Meeting 3 Goodfriend was the first patient to bring up personal material for group discussion, telling at length of intimate, painful childhood experiences. Small and Cann associated to this with similar childhood experiences.

DISCUSSION: In the first two meetings of the group all the patients but Goodfriend and Small had talked about intimate concerns. The doctor had repeatedly encouraged their making observations on each other, and early in Meeting 2 Bridges had picked up the technique, mentioning for example, that everyone seemed afraid to speak. Bridges used this technique again by calling attention to an attitude of Goodfriend's when he wanted to terminate a discussion with Cann which had become too uncomfortable for him. Goodfriend's previous defensive reticence about himself may have contributed to the group's readiness to follow Bridges' lead in discussing his problem with him. That is, Bridges' intervention was in line with the group's desire that Goodfriend open up. They continued to support him by their serious attention, which included helping him to understand himself as well as merely comforting him. The last interchange of Meeting 2 indicated that he had become part of the group and this was confirmed by the ease with which he talked of himself at the beginning of Meeting 3.

TENTATIVE DEDUCTION: In this situation a resistant patient was drawn out, after most of the others had talked of intimate concerns, by a pertinent comment on his defenses and the serious consideration given to an underlying problem of his by all members of the group, who were ready to turn their attention from their own problems to his.

In the following situation analysis a silent patient was drawn out by the doctor's calling attention to his anxiety and the group's support.

*Situation Analysis 32***DR. N'S GROUP I, Meeting 54**

**PRESENT:** Milton, Eubank, Trippitt, Coombs, and Weber

**SETTING:** Eubank's chronic anger was close to the surface, and he was fearful of expressing it. He distrusted practically everyone and tried to drive people away. His participation in the group had consisted mostly of brief questions to other members or of brief discussion of superficial problems. He was very dependent on the doctor and talked much more freely in individual therapy about trying to make people angry, trying to drive his wife away, and his fantasies of killing anti-Semites. He also talked about his reactions to the group, especially his uneasiness and his silence, and his fear of killing people who disagreed with him. The group was deeply concerned with hostility among the members and toward the doctor but was basically dependent on him and compliant.

Early in this meeting Dr. N asked Eubank about his reaction to a remark of Coombs' concerning his fear of killing his father. Eubank said that lately he hadn't been irritated or angry with anyone, even at work. The doctor asked if he had any notion why his anger had gone away. Eubank said he couldn't understand why nothing bothered him—it was a strange thing. The group remained silent and apparently uninterested. The doctor then questioned him about whether he had decided to stay in Washington or go home to Cleveland. After saying that he knew he didn't want to stay in Washington, Eubank remarked that he was sweating.

**EVENT:** Dr. N asked Eubank in a friendly way what he was sweating about. Eubank said that he felt "on the spot" when he talked, and it made him sweat. When Dr. N asked him about this, he responded that talking always did this to him anywhere. He felt guilty about not contributing much. Dr. N: "Guilty—to whom?" Eubank: "To the group for not talking enough."

**EFFECTS:** At this point other group members showed an interest in Eubank and tried to bring out what was associated with his guilt feelings and inability to talk in the group. He denied any feeling toward others in the group. Trippitt recalled a time when Eubank had shown resentment toward the group. Eubank recalled this with difficulty as a lack of trust but denied resentment. Milton referred to this incident in a supportive way. Eubank said he felt that he was not progressing as the others were and had become disgusted with himself. Trippitt asked against whom he might feel resentful and pointed out that the doctor also was involved. Dr. N recalled that

Eubank had said he was "on the spot," but Eubank couldn't explain what he had meant.

The doctor then said that if the present situation made Eubank tense, he probably couldn't think and should drop the matter. Eubank then admitted that he might be defensive, and the doctor asked what he was defending—was there a fear of exposure? Trippitt said that something must be making Eubank sweat. Coombs and Weber talked of how their own hands sweated. Weber asked Eubank if the memory of the group stayed with him when he left. Eubank said that even the points that involved him were out of his mind by the next week. All the others in turn mentioned that they thought about the group after the meetings. Weber asked Eubank if he purposely put the meeting out of mind.

The discussion then turned to Eubank's fear of expressing anger and his repression of feelings. He told of his feeling that anything he said was wrong, and Trippitt linked this to fear of speaking in the group. Eubank then denied any feeling of discomfort or anger. When Trippitt and Weber questioned him rather insistently about why he kept quiet, he went back to his childhood fear of being reprimanded and compared talking in the group to a public performance. He then spoke about his hostility to his father and his sister and his father's quarrels with his mother. The group then discussed with him the possibility of his silence being caused by his fear of being a disruptive force in the group.

DISCUSSION: Eubank could not directly express his anger, which was always just below the surface, but it came out in somatic manifestations. Direct questioning failed to draw him out, but when the doctor called attention to the patient's sweating, he elicited feelings relevant to the immediate situation. This gave a lead which the group explored, following Dr. N's leadership. When the doctor pointed out that Eubank's feeling of guilt must be directed toward someone, various patients questioned him about his feelings toward the group and recalled evidence of anger and resentment on his part.

When Eubank had made it quite clear that he was disturbed by having to talk in front of people, Dr. N showed his understanding by suggesting that Eubank need not continue. Other group members followed the doctor's leadership in supporting Eubank by bringing up similar feelings and showing interest in his. After this acceptance the discussion went back to his anger, and he began to talk about his hostility toward his family, a degree of intimacy which he had previously been unable to achieve in the group.



**TENTATIVE DEDUCTIONS:** A patient whose anger was close to the surface was hampered in participation in the group by fear of expressing his anger and of being criticized. His participation was facilitated by focusing on a physical manifestation as an expression of feelings relevant to the group situation and by the understanding of his emotions shown by the doctor and the other patients.

In the following situation analysis a patient's resistance, which took the form of intellectualizing, was overcome by an offer from the group to accept him if he would drop his defense.

### *Situation Analysis 33*

#### **DR. N'S GROUP I, Meeting 47**

**PRESENT:** Coombs, Eubank, Gugis, Milton, Trippitt, and Weber

**SETTING:** Trippitt, the central patient in this situation, defended himself against his own feelings and the emotional impact of other people by maintaining an attitude of intellectual superiority. He wished to free his emotions and had a strong need for approval from peers as well as authority figures. He was an only child.

Coombs, an ambulatory schizophrenic, participated in the group either by pouring out emotion in a baffling way or by concentrating on the problems of others. He had keen insight, but his interpretations were generally barbed as well as accurate. He expressed hostility more freely than anyone in the group, particularly toward Trippitt.

Dr. N had given tacit approval in the group and open approval in individual sessions to the free expression of hostility in the group. The patients were dependent on him and showed some rivalry for his approval.

In previous meetings it had been customary for patients to reveal personal problems, often speaking directly to the doctor and sometimes to the group. Others had been free to question, give advice, and offer interpretations, either hostile or friendly, to the member who talked about his problem.

Trippitt had been the outstanding object of hostility, the attacks being led by Coombs, who was diametrically opposite in his dynamics and behavior. Whereas Trippitt behaved in a superior and arrogant manner without emotion, Coombs acted deferential and inferior with a great show of feelings. Both had sought the doctor's attention, Trippitt by getting the group started in discussions and by imitating Dr. N's way of questioning, Coombs by being compliant in producing associations and bringing out much lurid material.

Coombs had complained in an individual session that Trippitt's

intellectualizing irritated him greatly. The doctor suggested that he tell Trippitt about it in the group, which he did at Meeting 38, showing intense anxiety: "You bother me more than anybody else here, you know. You seem so damned intellectual. For instance, this situation here—you start to discuss your skin rash, and everyone tries to question you and you're like a man in armor . . . because what they're trying to say is that there's some defect in Trippitt and Trippitt is sure that there is no defect, you know?" Weber, after more interchange, said, "In many respects I agree with what you said in regard to Trippitt. It seems that when we get to the intellectual stage in regard to Trippitt it gives me a feeling of being under." Later Gugis added, "You know, Trippitt affects me more or less the same way he does Coombs. He seems to be an observer, an understudy for the doctor. He's too logical for anything to be the matter with him."

Trippitt showed his emotion after this by replying, in unusually halting speech and with frequent nose-blowing, "To esteem me as something intellectual sort of flatters me because that's something I have been trying to be all my life. On the other hand, it makes me think of how futile and how absolutely valueless that intellectuality is, because I think a good part of my troubles here are just from that one thing. It makes me feel that, Jesus Christ, the things that ought to help are hindering—makes me feel the futility of the whole business more acutely than otherwise."

In Meeting 39 Trippitt for the first time brought up an obviously deep emotional problem—his fear of homosexuality. He was reassured and rewarded by all the other patients' expressing similar fears.

It was at this meeting that Weber attacked Trippitt violently for not accepting his Jewishness. This led to a feud which went on intermittently for the next eight sessions.\*

At Meeting 47 Trippitt presented in intellectual terms a deeply emotional problem about his girl. He thought that his neurotic tendency would never be completely removed and that he ought to compromise by finding a girl like his mother, since he actually felt happier in being dominated. Dr. N asked what the group thought about it. They tried unsuccessfully to discuss it with Trippitt. Dr. N also attempted to get Trippitt's real feelings, but this led nowhere.

PRECIPITATING EVENT: The focus of the discussion then went to Weber, who said that he had discovered that he liked people better after a scrap and that he liked Trippitt better now that they had had a fight. Trippitt rejected this by saying that the tension between them was unresolved—"I don't want your affection. Your being here (in the

\*See Chapter x, pp. 237 ff.

group) is evidence of your not being right." When the group pointed out that he had accepted the dislike which had previously been expressed toward him, he acknowledged that this dislike rankled.

**EVENT:** Weber and Coombs attacked Trippitt for feeling that hatred was the only emotion in the group which was valid, making it clear again and again that Trippitt rejected the positive feelings of the group toward him and reacted only to their hostility. Dr. N commented similarly. Coombs finally told Trippitt of a fantasy he had had in which he said, "Trippitt, I love you very much," and Trippitt replied, "Do you know how Webster defines love?"—the latter remark illustrating how Trippitt used his intellectuality to separate himself from people despite friendly overtures.

**EFFECTS:** In Meeting 48 Trippitt was very much upset. Referring to his inability to accept positive feelings, he told the group how he had made up a list of former girl friends and had realized that all those who had expressed warm feelings for him were "suspect." He then broke into sobs—the first time he had displayed any emotion. In an individual session immediately following he cried again, saying that he had discovered that he believed no one could like him because he had "no sincerity at the core." He had been living behind a façade and the liking people showed for him was for the façade and not for himself. At Meeting 49 Trippitt remarked that this was the second time in ten years that he had cried. He would have expected to feel humiliated but he actually felt relieved. Thereafter he showed intense emotions freely in the group. He stopped much of his intellectualizing. The change carried over into his relationships outside, especially with his parents and his girl.

Much later, in Meeting 70, Milton commented favorably on the change in Trippitt, who spoke more softly, with less drive and more willingness to see someone else's viewpoint. Trippitt said he thought that "the crack came in the group" when he saw that his suspiciousness was of those who liked him. He felt now that he was closer to being cured.

**DISCUSSION:** Trippitt had dealt with people by presenting a front of self-sufficient superiority but wanted to get closer to them. He could not show the group that there was anything really wrong with him. His talk tended to be about someone else's problem. The group finally attacked this and his rejection of the group except when it was hostile to him. They were saying, in effect, "We are mad at you because you won't let us like and help you."

Trippitt had not overcome his defenses in individual sessions,

possibly because Dr. N had not succeeded in conveying his disapproval of the patient's intellectualizing, since he occasionally lapsed into it himself. The doctor also had failed to see a crucial part of the problem until another patient pointed it out—that Trippitt could accept hostility as genuine but not friendliness.

The group accomplished a change in Trippitt's attitude by first showing hostility, which he could accept as genuine, and then by showing that they saw through his front, disliked it but were ready to like and help him. This enabled him to give up his façade of intellectual superiority and opened the way for further readjustment in attitudes.

**TENTATIVE DEDUCTION:** In this situation a patient's resistance, shown by intellectualization, was broken down by the insight other patients gave him into this defense by examining in a hostile way his refusal to accept anything but hostility as genuine and then offering to accept him without this defense.

Table 13 summarizes Situation Analyses 31-33.

### SUMMARY AND IMPLICATIONS FOR THERAPY

The foregoing situations, in which patients' resistance was mitigated or resolved, had several features in common:

1. The resistant patient particularly feared exposure of inferiority or unacceptable feelings, and this seemed to be an important determinant of his resistance.
2. All but one of the resistant patients tended to rely on achievement or performance to maintain self-esteem, and most were highly competitive.
3. Other patients had already expressed their feelings and talked about personal experiences.
4. The resistant patient shared in the general tension of the group. In early group meetings this may have been at least partly due to conflicts over talking.\*
5. A situation had developed which stimulated the resistant patient to participate because of its association to a source of his resistance.
6. In this situation one or more members of the group, with or without the doctor, helped the patient to resolve his resistance.

\*See Chapter v.



TABLE 13. Resistant Patients Who Participated after Group Members Had Criticized Their Defenses but Supported Their Underlying Problems

	<i>Dr. N's Group III, Meeting 2 Situation Analysis 31</i>	<i>Dr. N's Group I, Meeting 54 Situation Analysis 32</i>
SETTING <i>Doctor</i>	Non-participant.	Active, supportive.
<i>Group</i>	All but resistant patient and one other patient had talked of themselves.	Group well acquainted, with undercurrent of hostility among members. Showed compliance with negative undertone toward doctor. All but resistant patient had talked about themselves.
<i>Resistant patient</i>	Goodfriend: reticent, distrustful, offered platitudinous advice, relied on technical skill.	Eubank: constrained, full of anger, unexpressed because he feared it; collaborated in individual treatment, dependent on doctor; usually silent in group.
<i>Person to whom resistant patient related</i>	Bridges: had talked about himself and was uncomfortable about it.	Doctor (see above).
EVENT	Bridges called attention to defensive attitude of Goodfriend's.	Doctor focused on Eubank's feelings while sweating, which brought out his sense of guilt toward group for not talking more.
EFFECTS	Goodfriend was supported by group as he talked of his fear of anti-Semitism and, at next meeting, of very intimate experiences.	Under insistent but sympathetic questioning by doctor and group, Eubank was able to talk about his fear of expressing anger and then brought out his hostility toward his family.

*Dr. N's Group I, Meeting 47*  
*Situation Analysis 33*

Active, supportive, trying to help Trippitt break through intellectuality; approved expression of hostility.

Patients were well acquainted; dependent on doctor; showed hostility and rivalry in competing for his attention.

Trippitt: relied on intellectual superiority for self-esteem; wanted to free his emotions and get closer to people; strongly dependent on doctor; had previously received indirect group support on admitting fear of homosexuality; attacked by group for intellectualizing.

Coombs: irritated by Trippitt's intellectuality.  
Weber: irritated by Trippitt's attitude toward Jewishness.

Weber, Coombs, and doctor pointed out that Trippitt could accept only hostility as genuine, after Trippitt had rejected friendly gesture by Weber.

Trippitt wept in next meeting on talking about his discovery that he suspected all friendliness. Group was tacitly acceptant. Trippitt continued to experience and express emotions more freely.

COMMON FACTORS

Same doctor, but attitude differed. Probably not a determinant.

Most patients had talked about themselves. In S. A. 32 and 33 they were well acquainted.

Resistant, directly or indirectly.

Doctor, or another patient questioning or responding negatively to resistant patient's attitude (see EVENT).

Resistant patient's attitude was sharply focused on; as he became less defensive, group supported him.

Resistant patient revealed personal problems related to his attitude in group.

7. In six out of nine examples these members had qualities which made it possible for the resistant member to identify with them; in two, the other member afforded the resistant patient an opportunity to speak on a topic on which he had special competence.
8. In early meetings overt support seemed more necessary than in later ones, in which considerable criticism could be borne and might even be helpful. In later meetings the support was implicit in the patients' long-standing interest in one another.

It would appear from our experience that the following points are useful for the doctor to keep in mind in dealing with resistance:

1. He can usually leave the leadership in this situation to the group, especially if there is a patient with initiative with whom the resistant patient can identify. In such a case the doctor can devote his efforts to facilitating the process of identification. Often this is best done by maintaining an interested silence. In this connection it may be mentioned that therapy is often facilitated if the doctor does not attempt to meet a challenge from a resistant patient but leaves it to the group.
2. In a newly formed group he should not attempt to get a withdrawn patient to talk about himself until others have set an example. In a mature group he need not be concerned about this, since others will have already done so.
3. He should be alert for situations in which members of the group express feelings which seem to be similar to those of the resistant patient, particularly hostile and fearful feelings about one another or the doctor.
4. He should seize the opportunity to take advantage of a response by the resistant patient to any occurrence in the immediate situation related to his feelings.
5. In a newly formed group explicit support of the resistant patient may be desirable and probably should be given by the doctor if the group fails to supply it. Essentially, support consists of taking a patient seriously and conveying the idea that an effort is being made to understand his problems. It may be indicated merely through withdrawal of pressure. In a mature group he need not mitigate attacks by other members on the resistant patient or offer

overt support. In fact, a certain amount of open irritation on the part of the other members may facilitate the resistant patient's progress.

6. He should remain alert to possible remote effects of such a situation.

### GROUP SILENCES

A silence involving the whole group, even though it lasts only a few seconds, is reacted to by each patient. It creates an awkward situation which has implications of social as well as therapeutic failure. A silence may mean to the doctor that he is in danger of failing as a therapist, especially if he assumes, as inexperienced doctors often do, that therapy cannot be progressing unless verbal communication is occurring. It may also arouse a sense of social failure at his inability to keep conversation going. In the early meetings of our groups the discomfort caused by silences was out of all proportion to their significance; hence toleration of silences by the doctors as well as the patients came to be regarded as a definite sign of progress. Brief silences were frequent and probably were necessary to the therapeutic process.

A group silence might indicate merely that no member had anything to say at that moment, in which case it represented a fortuitous collection of individual silences, or it might express an attitude shared by several members. In such cases the attitude leading to silence usually arose out of the immediate group situation, and the silence represented a community of feeling which was predominantly negative. Since the group could not express this emotion directly, the doctor had to seek the underlying cause.

As a rule, silences lasting more than a very few minutes became matters of group concern. Secondary attitudes then came into play, such as shared uneasiness or a competitive attempt to maintain the longest silence.\* Although hostility or resistance was usually involved, other factors might play a part. A group silence might be an expression of the fact that other patients were mulling over or trying to apply to themselves what one patient had just said. This might be called the silence of digestion. A silence might also result from the group's being at a loss, as when one patient presented material that was so

\*See Situation Analysis 14.



remote from the experience of the others that they were unable to respond to it, or when the group had come to expect a certain patient to talk and he failed to do so, as in the following example.

In the first few meetings of Dr. P's Group 1 Merrick had been the monopolist. At the start of Meeting 5 he announced that he had just been through his whole story again with the social worker. He protested that the comments of the others had done him no good and became silent. No one else spoke. When the doctor raised a question about the meaning of the silence, Merrick expressed his discontent with the group for waiting for him to speak and then continued again as usual with his difficulties about his girl.

Finally, the group might be at a loss if the doctor seemed to be at cross-purposes with it, as in Meeting 65 of Dr. N's Group 1, when the group apparently wished to talk about the death of a member and the doctor did not. Under such circumstances a silence also includes a component of unexpressed annoyance or hostility toward the doctor.\*

The following account of a prolonged silence in Dr. N's Group 11 indicates the welter of feelings that may be contributory to such an episode.

Before the silence there had been a period of rising tension, which began in Meeting 73 with an episode of acute patient-to-patient antagonism. In Meeting 74 the patients seemed less tense and rather freely examined their feelings. Toward the end of this meeting Bly, who had intense but very mixed feelings toward the doctor, said to him with an embarrassed laugh, "I was just thinking—you're on my level, you're a normal person—I'm just wondering, does your wife do your shirts?" Coombs said he thought the doctor would say, "How dare you!" to Bly for suggesting that they were on the same level. Bly said that he got a headache from just thinking of it—he couldn't get over his daring.

Bly opened Meeting 75 with a recital of anxiety symptoms which had begun after the previous meeting. When Dr. N tried to remind him of what he had said about bringing the doctor down to his level, Bly remarked that he was thinking of the doctor as another man who had the same troubles as he did. Then he began to talk of his wife and his father, about whom he had severe conflicts over dependence and hostility, and then said to the doctor, "You know my case is coming back to the Board (for a pension decision). I was thinking you might

\*See Situation Analysis 14.

recommend that I not get anything. One thought was that I would come in here and hit you. Another was I would be free of it all. Another was that it wouldn't be right to hit someone smaller than myself. But my last thought was, you'd just forgive me anyway." The doctor pointed out Bly's conflict between feeling both very weak and very strong. Bly agreed and then went on to mention his fear after he had told someone off at the office. Although Bly's tone was one of complaining and seeking help, Dr. N deliberately chose to focus on the evidence of improvement, as shown by greater awareness of emotions. When Dr. N said, "Things are getting better, aren't they, at least they're showing signs of yielding," *an eighteen minute silence ensued*. The doctor raised the question whether this was related to the tension in the group and possible hostility to himself, but no one responded.

Finally, Dr. N noted that Ingram seemed to want to speak and asked him if he had something to say. The patient embarrassedly responded that it was up to someone other than Mr. Bly to "take the stand," and Bly and Coombs told of their hesitancy to talk. Ingram referred wistfully to a patient no longer present who would always "carry the ball" and then talked of hostility toward his companions on a recent hunting expedition.

Dr. N brought them back to their feelings toward him. Coombs: "When Bly said that about striking you, I was depressed. When you were sitting there so close to me, I wondered how you knew I wouldn't hurt you. Then I wanted to put my arms around you." The doctor wondered if it might not be harder to express affection than hate. Coombs immediately associated to this—the fact that displays of affection used to drive his mother crazy—"She just didn't know how to react to it." Bly added that for him it wasn't right to have affection for others, and that when he tried to be friendly he got a tingling sensation all over. By now the group had markedly relaxed. Ingram talked comfortably about his difficulty in becoming intimate with girls.\*

In this situation the silence seemed to be due partly to the group's being at a loss because Dr. N and Bly seemed at cross-purposes when the latter implicitly appealed for sympathy and the former misinterpreted his behavior as indicating improvement. The conflicting feelings toward the doctor may have been very important in causing the silence. The affectionate ones seemed the more difficult to express.

As in individual therapy with neurotics, the doctor usually does not have to do anything about a group silence. It seldom lasts long enough

\*This tendency for a patient to hold the floor comfortably after a period of tension is described in Chapter VI, p. 145.

to be a waste of therapeutic time, and almost always a patient will break it before it becomes a real problem. In general, the therapeutic potentialities seem to be greater when the doctor waits for a patient to speak rather than when he breaks the silence.

If the silence has continued for some time and the doctor feels that there is a competition as to who can best endure it, a direct question in regard to the cause is seldom profitable, since the silence itself indicates that the feelings responsible for it are momentarily inexpressible. Instead the doctor may speculate on the cause of the silence, hoping to stimulate assent or denial, but not directly asking for a response. When the block is severe this may also fail, as it did in the above example in which the silence was finally relieved by the doctor's support of the patient who seemed to have the greatest need to speak. Here the doctor adjusted to the feelings of the patients instead of opposing them. This is a generally useful technique. In the following example another type of intervention relieved a silence which threatened to become a serious block.

In Meeting 85 of Dr. N's Group II Bly described his fear of wanting to kill his baby. A long and uncomfortable silence followed. The doctor finally reminded the members that they had gone to some trouble to come to the meeting and, therefore, presumably did not wish to waste their time—their silence must mean either that they were getting some benefit from it or that something was preventing them from speaking. Coombs then told of the deep self-hatred he felt, not because of his thoughts of killing his family, which he knew were unreal, but because of what he did to people in reality, especially his wife. Ingram immediately described his fear of telling a girl he loved her, lest she take advantage of him, and this led to a community of feeling among Bly, Ingram, and Coombs regarding their distress over being unable to express affection. This silence, which threatened to impede therapy, involved the problem of affection as well as hostility, as did that of the previous example.

The examples cited above may suffice to indicate that group silences, although disturbing, especially to inexperienced doctors, seldom present a major problem with neurotic patients, and that when they do they can best be dealt with by the therapeutic techniques commonly used in overcoming resistance.

## CHAPTER XII

### *Introduction of New Members*

---

IN setting up our project we refrained from determining in advance whether our groups would or would not take in new members after a certain number of meetings had been held. Some indirect pressure to take in new members was created by our desire to treat as many patients as possible by filling in the gaps when the regular attendance of a group had fallen off to three or four, but once a group had begun to function considerable reluctance to admit new members seemed to develop, and this reluctance increased after a certain point. Although sixty-four patients (51 per cent) were introduced after the first meeting, forty of these were added before the tenth meeting. The great majority of them had been on the original roster but had failed to attend at the start. With only one exception there were no admissions of new members after the twenty-third meeting of a group. The exception had long been a member of a recently disbanded group led by the same doctor.

This tendency for our groups to become closed is related to the fact that our method of therapy was intensive and analytical. The doctors feared that new members might set the group back because they were at different stages of treatment, unfamiliar with the mores of the group, and especially because they would come as strangers into a group with a network of intimate relationships. The older the group the more potent these considerations were.

Our data show no relation between time of admission and whether or not the patient became integrated in the group, indicating that before the twenty-third meeting the age of the group was not a significant factor. Our one experience in introducing a new member into a



well-established group made a difficult situation, even though the new member had been in another group led by the same doctor.\*

The introduction of a new member can best be considered as a particular type of stress for the patient himself and for the group. The new member is subjected to all the uncertainties that surround any initial group meeting, as discussed in Chapter v. If the group has been running for some time, he is also under the additional strain of knowing that the other members are well acquainted with each other and have ways of proceeding with which he is unfamiliar. His state of mind tends to be somewhat like that of the new member of a club, who is not sure whether he will be accepted or how he should behave to win acceptance. For the other members, the new one is an unknown quantity and may prove a threat on several counts. In any event he is one more claimant for the doctor's attention. He may prove to be a rival for the position occupied by another patient, such as that of the most intellectual or the most able to talk of personal problems. How the patients react to these stresses depends on their personalities, the mores of the group, and what the doctor does. The following four situation analyses illustrate some of the patterns observed.

Situation Analyses 34-36 illustrate difficulties arising from the introduction of new members. In Situation Analysis 34, which is unique in that the new member had had more individual and group psychotherapy than the others, his introduction caused a marked rise in tension and regressive behavior, partly because the doctor had failed to take sufficiently into account the feelings of the old members. It led to a persistent feud between a newcomer and the old member who had the strongest desire for the doctor's attention. This conflict could not be used therapeutically. The great dependence of both patients on the doctor was probably their only reason for remaining in the group.

#### *Situation Analysis 34*

##### **DR. N'S GROUP II, Meeting 62**

**PRESENT:** Bly, Veal, Ingram, Castell, and Coombs

**SETTING:** No newcomers had appeared in this group for forty-seven meetings. At Meeting 60 four patients remained. After this session

\*See Situation Analysis 34.

Dr. N went on a month's vacation and the patients had no psychotherapy. Just prior to this he had disbanded another group because most of the patients were leaving the city. One patient remained for treatment, and Dr. N decided to take this patient into Group II.

The patients in Group II tended to relate primarily to the doctor and only indirectly to one another. In Meeting 61, the first after Dr. N's return, the patients talked about their dependency on him and their feelings of helplessness. The doctor told them that another patient, who belonged to a group of his which had recently disbanded, would join them at their next meeting, and asked the patients to express their feelings about this. He conveyed by implication that their feelings would not influence his decision. Bly, the only patient to express resentment, objected that another man would "slow down" the group's progress and would increase the number of people who would know his story. Ingram said it made no difference to him. Castell said nothing. Veal was absent.

Coombs, the new patient, had had nearly a hundred sessions of individual and over a hundred sessions of group treatment. He had played an important role in the group to which he had formerly belonged and occupied a large part of the doctor's attention. At the time of his pending introduction to the new group, Dr. N thought that Coombs felt somewhat rejected by the doctor because his individual treatments had been terminated (for administrative reasons) and because he had received no psychotherapy for over a month. In the past his behavior in group and individual therapy had been extremely compliant and dependent, but he had shown much ambivalence toward the doctor.

After the introduction of the new member at the beginning of the meeting, Bly talked aimlessly about his symptoms and problems for thirty minutes. Occasionally he lapsed into a brief silence, as though he had lost his train of thought, but he was not interrupted, although the other patients seemed tense and inattentive. Throughout Bly's soliloquy Dr. N made repeated attempts to reflect his comments, interpret, or question him, but Bly responded by changing the subject.

**EVENT:** When Bly paused after having talked for half an hour, Dr. N commented that the group seemed constrained and suggested that it was because of the presence of the new member. He asked whether Bly noticed that he had shut Mr. Coombs out completely. The doctor pointed out that Bly seemed to be trying to demonstrate that he was "the favorite son" and had the inside track in this group.

**EFFECTS:** Bly remarked cryptically that Coombs didn't look as if he

belonged in a therapy group and that he, Bly, felt he had something important to say and didn't want to wait until Coombs was ready to talk. He added that he wanted to make sure the group would go on as usual. When Dr. N tried to find out what Bly meant by these statements, the latter again shifted the topic and then lapsed into silence. Ingram said apologetically to the doctor that he hadn't wanted to speak up because he thought none of his ideas were important. With considerable questioning by Dr. N, Ingram remained in focus for the next half hour, although he appeared extremely reluctant to speak. The patients seemed tense and constrained and did not associate with Ingram's material.

While Ingram was talking about the onset of his illness in the service, Bly abruptly interrupted with a change of topic, saying, "I'll tell you a thing that bothers me—that blue sign in the hall that points the way to the Mental Hygiene Clinic." Both Castell and Ingram agreed with Bly that they, too, were bothered by the sign and wondered why the clinic didn't get rid of it; both said that they didn't like the public to know they came to the clinic. Coombs responded to Bly's comment, saying, "That's why they put the sign here. They figure it's easier to see it than to ask where it is." To a question from Dr. N, Bly replied that he objected to the sign because he was ashamed of what other people might think of him. He then tried to shift the topic to his relationship with his wife, but Coombs interrupted him and brought the point back to the sign, saying scornfully, "You say we ought to educate the public? That's a pretty big way of talking. The main thing is to educate ourselves, and then we won't have to worry about what the general public thinks." Dr. N agreed with Coombs. Bly did not answer Coombs but a few minutes later asked Ingram the same question about his father that Coombs had asked half an hour before. Except for this neither Bly nor Coombs talked during the remaining fifteen minutes.

The tension (which the doctor believed was due to the presence of the new member), although temporarily somewhat diminished following the rally around resentment against the Mental Hygiene Clinic sign, continued for five meetings; no patient responded to any of the doctor's questions about the new member or verbally expressed his feelings about him. There was, however, an increase in overt and indirect hostility toward the doctor.

DISCUSSION: The members were tense and anxious over the entrance of a new patient and reverted to their old defenses, which had been partially abandoned. For example, Bly, the most talkative patient in the group and the one who most openly sought the doctor's exclusive

attention, continually strove to get the center of the stage; Veal and Castell, the least talkative members, again became completely silent. Ingram, who had previously been in great conflict over accepting therapy at all, reverted to the idea that his pains were organic. The new patient reverted to his pattern of waiting to see what the doctor did before doing anything himself and followed all the doctor's interventions with parallel ones.

The resentment of the Mental Hygiene Clinic sign seemed to represent a thinly disguised antagonism toward the doctor. The introduction of this rallying topic by Bly seemed to permit Castell and Coombs to speak for the first time. The hostility toward the doctor may have been due to the latter's asking members to express their feelings in regard to admitting a new patient after he had told them that the new man was coming, indicating a lack of respect for their wishes. Further, the attitude of the patient who expressed resentment of the idea was not analyzed before the new man arrived. The fact that the new patient was a former patient of Dr. N's might have increased the group's jealousy. The doctor's absence on vacation had intensified the patients' dependency.

Dr. N interpreted Bly's behavior several times in order to help him see that it undermined his self-respect, but the doctor's irritation made him speak critically rather than understandingly. (In previous meetings Bly had been able to examine profitably similar actions and what prompted them.) Dr. N's interpretation stopped the monopolist but failed in that it blocked everyone else, possibly because the patients were hostile toward him for presenting the idea of an addition to the group as *fait accompli* and did not want to talk. His intervention was unsuccessful because he did not recognize that the group's anger was based on the way in which he had introduced a new member. It was also felt as a rebuff, which served to heighten the general tension. Ingram's initial apology seemed to imply that he expected to be criticized next.

Bly asked Ingram the same question about his father that Coombs had previously asked with the apparent approval of Dr. N. This may have been to gain support from the doctor.

**TENTATIVE DEDUCTION:** In this situation it appeared that when patients were tense, anxious, and unable to express their resentment toward the doctor over a disturbing occurrence in the group they rallied around a seemingly unrelated topic and expressed resentment against it, leading to some relief of tension (see Situation Analysis 5).

Situation Analysis 34 is summarized in Table 8.



Situation Analyses 35 and 36 show how a new member may not be assimilated by the group even in very early stages if his personality impels him to resist the group mores and if the doctor does not accept and examine the group's refusal to accept him.

### *Situation Analysis 35*

DR. K's GROUP, *Meetings 3, 4, 5, 6, and 7*

PRESENT: Attendance varied

SETTING: Monroe, the central patient of this situation, had physical complaints associated with anxiety attacks. He did not fully accept the idea of a psychological basis for his complaint. He tended to belittle others and claimed to be a reactionary whose personality was "out of tune" with present-day society. He entered Dr. K's Group at its third meeting, after considerably less individual therapy than the rest of the group had had, and gave up treatment, unimproved, after five group and five individual sessions.

During this period the doctor participated relatively little in the activities of the group, and the patients had related at the first two meetings in ways which were comfortable to them. Steele had appeared as a pedant concerned with the logic of discussions. In equally pedantic fashion, Turner argued in favor of free association. He had presented himself as having had much worldly experience and as an authority on psychoanalysis. Hammond was rebellious to a certain extent, but became ingratiating when his bluff was called. The group patronized Boyden, who made no claims. Mercer, who had entered the group at Meeting 4, had complaints similar to Boyden's and was unpretentious and compliant with the group's attempt to probe and advise him.

EVENTS: The members successfully blocked Monroe's attempts to lead the group into impersonal topics and to advise other patients.

At the opening of Meeting 3, after comments about the weather and a brief silence, Monroe produced an outline for interviewing. He questioned the group on some of the items. Steele interrupted him to explain that they had been in the habit of discussing themselves and proceeded to talk about his stammering. Monroe explained that he, himself, had got over stammering, then stated his opinion that one is justified in exploiting any situation—"I've often said that if a shady opportunity came along I might jump right into it. . . . If I were a businessman I'd be a Republican. . . . Now it suits me to be a Democrat."

In Meeting 4, when Monroe replied to remarks of Turner's about

the U.S.S.R., Turner cut the discussion short by asking, "Wouldn't someone like to present his problem?"

Boyden responded to this invitation by telling of his lack of interest in finding a job in the field of accounting, in which he had a degree. Monroe advised him and lectured on the interpretation of vocational placement tests. Turner and Steele immediately became protective of Boyden. Turner: "I don't think a discussion of the relative merits of different professions would be very valuable here. . . . More likely you're trying to fight an old fight of infancy." In reply to Monroe's next question to Boyden, Steele said, "Mr. Boyden has already gone into his past life with Mr. Turner and me."

In Meeting 5 Mercer was asked by the group to speak first. He presented a complaint similar to Boyden's. When Monroe responded with a lecture on vocational difficulties as a problem of the post-war generation, Turner ruled him out of order, saying that it was a problem to Mercer in addition to being a problem of the times. Steele, in a kindly way, suggested to Mercer some ways of beginning to talk about himself as the rest had done and mentioned some of his own family relations. Monroe confined his participation for the rest of the meeting to giving the definitions of terms such as "friends" and "alcoholism."

EFFECTS: Monroe attended only the next two meetings, during which the members attacked him more directly, and he attempted to show that the group was not important to him and that psychiatry did not apply to him. When Dr. K asked, "Monroe, how do you feel about this cross-examination?" he replied, "It doesn't bother me. . . . I was bored last time. I feel we all come in here with a false front. Let's get down to brass tacks—all this 'ecolistic talk.'" Trill observed that this neologism showed that Monroe was guilty of his own complaint. Trill continued, "Well, I want to know if your trouble is psychic." Monroe: "I'm not sure, there's so much that medicine doesn't know." Dr. K to Mercer: "What role are these fellows playing? What does this behavior toward Monroe mean?" Mercer: "I had a feeling they were ganging up on him." Turner: "I accept the accusation." Monroe fired a series of questions at Trill and concluded, "Your shamefulness is brought about through ignorance." When Dr. K asked, "What's gone on here in the past three minutes?" Mercer suggested that the group had been uncomfortable. Monroe: "I wasn't uncomfortable. Why should I be uncomfortable when someone else is talking? I'm after answers to my questions, and if I can get them by interrupting him, that's good." In Meeting 7, Monroe's last, he described his marriage as perfect but told enough to raise doubts.

At his next and last individual session, Monroe reported, "These

characters gave me a very guilty conscience when I went back to my wife last time. From now on it's lie to them. I'm not telling them anything more about my sex life. I was just trying to help them, but no more; that's something super-personal. It's not that I'm ashamed, but it's something strictly between my wife and me."

DISCUSSION: From the start the group showed Monroe that there was no opportunity for his leadership. When he attempted to take over leadership by advising Boyden and Mercer, he was promptly excluded. In his efforts to gain acceptance by discussing personal problems he revealed more than he had intended to, which seemed to be the final straw.

### *Situation Analysis 36*

DR. X'S GROUP, *Meetings 3, 8, 9, 13, and 16*

PRESENT: Attendance varied

SETTING: Janeway, the central patient of this situation, had a diagnosis of psychogenic backache. He had an important administrative position and appeared to be very pedantic. His emotions found expression in bowel dysfunction or occasional tantrumlike anger.

He entered the group at Meeting 3, after eight individual sessions. The rest had had over twenty sessions of individual therapy with Dr. X. The doctor actively directed the group, and the members were compliant, with the exception of Grey, who was eloquent in his rebelliousness. All gave much personal information, comparing their experiences and advising one another. All at times told how much they had been helped.

In summarizing his difficulty to the group Janeway said in an early meeting, "I always throw up a veneer of antagonism, defeating my own purpose—which is to be liked." He had great sensitivity to what people thought about him but he reacted with contempt and suspiciousness. He told about the great pains he had taken and pleasure he had experienced in selecting appropriate gifts and his doubts of the sincerity of thanks he had received, then anxiously asked for another patient's reaction to what he had said. At a later meeting, after expressing suspiciousness of his associates, he pointed to a patient who had been for the most part silent, and said, "I want that man's opinion, I think we are alike." He was prone to brag about "playing angles" and "getting even" and to offer numerous mystical theories to explain neurosis. As an example of his "trickery," he claimed to have made a fool of a superior by apologizing abjectly. "He's one of my best friends now, the damned sucker." Unlike most of the other members

of the group, he could not say that he was being helped, since giving praise seemed associated with hostility.

**EVENTS:** In Meeting 8, observed by several visiting psychiatrists, each patient had introduced himself and told something of his progress in therapy. When called upon in turn, Janeway, more resistant than the rest replied, "I'm very sensitive, I wish I could be closer to people. I have a pain in my back. I'm not convinced that it is organic, nor that it is inorganic. I came because I didn't want to leave any stone unturned. I feel much closer to the group than to people I have known for years. I'm not sure that it is good or bad." When Dr. X asked about changes, Janeway said that his basic convictions had not changed but that he was more careful, because in the past he had fooled himself about changes.

In Meeting 9 the group began to express reactions to recent events. Janeway was vehemently profane in his anger over the presence of visiting psychiatrists, especially a woman, at Meeting 8. He complained that it had caused restraint in language. Janeway made friendly overtures to Grey, who responded by objecting to Janeway's speech, "I don't use such language before anyone."

Dr. X invited Janeway to say what he had hesitated to say at the previous meeting. Janeway replied that he had wanted to speak of his revulsion at the seemingly magical cures to which testimonials were given. He said that he did not read the items Dr. X had recommended because such "stuff" was written for the average man. While he reacted to what happened in the group, he could not, like the others, analyze the reaction.

**EFFECTS:** Janeway, who had attended five of the first nine meetings, returned only to Meetings 13 and 16. In Meeting 13, while the rest were frankly resistant to the doctor, Janeway was only obliquely so. He told more of how he had learned to deal with power by craftiness.

In Meeting 16 an especially compliant patient gave some evidence of improvement which he attributed to the doctor. Dr. X hesitated to accept this and turned his attention to Janeway. Dr. X: "Do you feel easier with people since you've been coming to the group?" Janeway replied, "Not a God-damn bit," and then qualified the point by saying that perhaps he got along better with his wife—"She is more human than these constipated officials I work with." He spoke of the officials' rigidity. Dr. X: "I think you have a tendency to try to avoid emotions by generalizing." Janeway attempted to justify this by arguing in favor of occupying the mind with work. When Dr. X asked if one could ever get away from dealing with people, Janeway



argued that, by dealing with them according to occupational function, contacts could be minimized.

Dr. X asked what the different members of the group wanted in life. After some had replied, Janeway said, "Your question is too vague. It bothers me." Dr. X: "All right, that brings up the question of why you have to have everything in life so precise; that's part of your neurosis." Montgomery asked Janeway if he wanted a blueprint. Janeway replied, "Such general questions demand general answers. How long is a piece of string? Two times the distance from the center to either end." He argued defensively that his attitude was necessary in view of his work situation. A patient then spoke of difficulties with his father, and Dr. X asked if they hadn't all scars from such relationships. Janeway rejected the idea that these had any significance and fell back on the theory which he had developed earlier to explain his difficulties. Janeway ended discussion by saying, "I've got a slogan, 'You never learn anything by talking,' but I keep talking."

Janeway did not return again to the group, although he improved in the year of individual therapy that followed.

DISCUSSION: This patient had chronic difficulties with superiors and co-workers and used gifts and compliments in order to manipulate people. As a newcomer he entered a group in which discussion of improvement under therapy was an important way of gaining acceptance. Despite a strong relationship with the doctor, or perhaps because of it, he could not admit progress, because to give compliments, in his eyes, would be a gesture of contempt. Instead he tried to make a place for himself by attacking the accepted group mores and advocating different ones. When the doctor and the group rebuffed these attempts instead of trying to understand the feelings which motivated this behavior, he left the group. However, he was able to continue in individual treatment, where there was no group to contend with and where he was the center of attention.

Situation Analyses 35 and 36 are summarized in Table 14.

The following situation analysis is an example of the successful integration of a new member into a group.\*

### *Situation Analysis 37*

#### *DR. Z's GROUP, Meeting 13*

\*Another example involving somewhat different mechanisms is Situation Analysis 29, in which two old members put on what seemed to be a demonstration for the new member of how therapy proceeds. The latter's assimilation was further facilitated when his conflicting attitudes toward the group were verbalized by the doctor.

PRESENT: Phillips, Kootch, and Stafford

SETTING: A new patient, Phillips, joined the group at Meeting 13. An ambulatory schizophrenic with a paranoid tendency, he characteristically wanted others to be more understanding of people's difficulties but suspected efforts to get information about himself. Kootch, a patient who assumed a front of mastery, urged others to act forcefully and tried to limit discussion to what he considered important. Stafford, an obsessive patient, felt safest from being found out when he was talking. He rarely exercised leadership but often diverted the group by talking with apparent concern about something that had little meaning for him. He suffered considerable guilt, according to Dr. Z, because his mother expected him to be as disrespectful to his father as she was.

When Phillips attempted to state the question the group was discussing, Kootch pointed out critically that the matter was more complex. A brief discussion by Kootch, Phillips, and Dr. Z was followed by a silence. The doctor suggested that group therapy might be embarrassing. Kootch apologized for "busting in" and then said to Stafford, "Go ahead and say something like you did last week, and I'll pitch right in." (Phillips had not been present at Meeting 12.) They reverted to the previous week's discussion of the criteria for a well-balanced personality in terms of a friend known only to Kootch and Stafford. When Phillips talked about his own parents in these terms, Kootch said that Phillips spoke irrelevantly and that evidently he had not followed closely.

Dr. Z then pointed out that they were discussing in generalities persons unknown to the group, by saying, "It seems as if we're getting away from the three of us." When Kootch and Stafford offered excuses for the topic, Dr. Z replied, "I wonder about this 'friend.' You say you both get angry at home but are more tolerant with outsiders."

Stafford diverted the discussion from the group's attitude toward Phillips as an outsider by replying, "When I came in here I was all hepped up with anger at my cousin and was taking it out on my mother." Dr. Z: "What was the situation there?" (The doctor had learned in an individual session preceding the group meeting that this cousin had consulted with Stafford's mother as though Stafford were not present.) While Stafford told what had happened, Kootch became tense and ripped off the cuff of his shirt. After about five minutes Stafford concluded that it was his pent-up anger at his cousin that he was letting off. Stafford said little more and seemed satisfied that he had made his contribution. Dr. Z: "From what you say, your cousin gave your problems very little attention, but your

TABLE 14. Failure to Integrate New Patients into Established Groups

	<p><i>Dr. K's Group Meetings 3-7</i>  <i>Situation Analysis 35</i></p>
SETTING	
<i>Doctor</i>	Passive, unacceptant of new patient.
<i>Group</i>	Members had had much individual therapy and two group meetings before introduction of new patient. Attitudes emphasized in group discussions.
<i>New patient</i>	Monroe: pedantic, unable to form ties of affection; could not let people become important to him; manipulated and exploited others to get ahead; weak relation to doctor in individual sessions; not convinced his problems were psychological.
EVENT	In each meeting Monroe tried to lead group away from personal problems and was rebuffed by other patients. Doctor did not intervene.
EFFECTS	Monroe, having rejected group and psychotherapy, under pressure from group inadvertently revealed something "super-personal" about relationship with wife; left therapy.

*Dr. X's Group, Meetings 3, 8, 9, 13, 16*  
*Situation Analysis 36*

Very active, unacceptant of new patient.

Members had had much individual therapy and two group meetings before introduction of new patient. Personal histories and reports of progress in therapy emphasized in group discussions.

Janeway: pedantic, unable to express affection on demand; casual acquaintances were excessively important to him; manipulated and exploited others and expressed contempt for them defensively; strong relationship with doctor; not convinced his problems were psychological.

Janeway, who had attended meetings erratically, expressed revulsion at progress reports of others; his generalizing attacked by doctor.

Janeway rejected doctor's techniques and left group.

#### COMMON FACTORS

Unacceptant of new patient's attitude.

Members had received more individual therapy from doctor than new patient had. Latter felt threatened by content of group discussions.

New patient's ways of dealing with others incompatible with mores of group.

New patient actively opposed group mores and was attacked by group or doctor.

New patient counterattacked and left group.



mother gave her a great deal of attention." Stafford said apathetically, "Yes, we did hit on a jealousy angle this morning." He gave further examples of his cousin's behavior. "She tries to thrust herself on you to master your soul." Dr. Z looked away. Stafford said to Kootch cordially, "Got any cousins like that?" Kootch growled, "I haven't any cousins."

EVENT: Dr. Z brought the discussion back to the subject under consideration when Stafford started his diversion (i.e., attitudes toward outsiders) by saying to Stafford, "At the beginning of this hour you seemed to stress your feeling of being an outsider."

EFFECT: The group broke up Stafford's monopoly by expressing feelings of inadequacy associated with being an outsider, which was directly related to their behavior toward the new patient. Kootch replied to Dr. Z's statement, "Do you think that's so unusual? Same thing occurred to me when I started—I think it's quite normal." Phillips: "I would like to meet certain people, but when I do I'm up against a barrier. . . . When the other individual makes the move, I pull into a shell." Stafford: "I have the same trouble." Phillips: "Does it weigh on your mind? It occupies mine most of the time." Kootch: "How does it seem? That you don't say the right thing?" Phillips recounted circumstances in which he had wanted to be cordial but could not. Stafford responded enthusiastically to Phillips, "That's the thing, it's the mystery." Kootch: "Just say 'hello'. . . . Well, just *say* it!" Then Kootch told about surprising himself with his own "guts" in such situations—"I walked up to (a psychiatrist) and said, 'Your face is familiar.'" Thus, as Stafford increasingly showed sympathy and interest in Phillips' problem, Kootch withdrew, intervening impatiently only to give advice.

DISCUSSION: Two old patients tried to keep a new patient out of the discussion. When Dr. Z tried to bring him in, one of the old patients told an anecdote which seemed relevant, but the doctor recognized it as a diversion because of the patient's lack of interest after finishing the story and his habitual avoidance of the examination of his feelings and motives. The doctor then succeeded in getting this patient to accept the new member by referring back to the point of departure for the anecdote, thus calling attention in a non-critical way to the feelings underlying the anecdote that were relevant to the present situation.

### SUMMARY AND IMPLICATIONS FOR THERAPY

The above situation analyses illustrate that the introduction of a new member cannot be considered independently of many other factors.

Both the newcomer and the group tend to show the defensive behavior that characterize their reactions to stress. Whether this proves therapeutically useful or not depends on the nature of the reactions in relation to a given group and on the doctor's ability to understand, accept, and analyze them. We have illustrated some of the more obvious ways in which the new member may react:

1. He may request information as to how to proceed (e.g., Bridges in Situation Analysis 29).
2. He may try to join in the discussion. Phillips tried this unsuccessfully (Situation Analysis 37), but Coombs, an old hand at manipulating others, skillfully inserted himself into the discussion (Situation Analysis 34).
3. He may try to run things in his own way, regardless of the mores of the group or the attitudes of the others. These tactics were used by Monroe (Situation Analysis 35) and in a different way by Janeway (Situation Analysis 36).

The old members of the group try to deal with the new member and the anxiety he engenders in various ways. In our experience the old members often tended to cut out the newcomer and to emphasize their own claims on the doctor. This is very clear in Situation Analysis 34, where Bly launched into a filibuster, and in Situation Analysis 29, where the old members asked the doctor for the conclusions he had reached about them from the last meeting. More subtly, the old patients may introduce a reminder of their prior claims, excluding the newcomer from the discussion, as in Situation Analysis 37, where Kootch asked Stafford to bring up something from the last meeting. In two cases not described one of the old members immediately asked for the whereabouts of an absent member, as if to emphasize his own previous belonging to the group.

Certain aggressive patients do not hesitate to administer a direct rebuff to the new member, as Turner and Steele did to Monroe (Situation Analysis 35), Grey did to Janeway (Situation Analysis 36), and Kootch did to Phillips (Situation Analysis 37). On the other hand, old members may remind themselves of the purposes and methods of therapy as a way of answering the new member's questions. In Situation Analysis 29, for example, when Minor joined with Cann in

an attempt to show Bridges how to proceed, he derived incidental benefit for himself.

These situation analyses illustrate further that the attitude and behavior of the doctor may influence the way in which the new member is received and determine whether anything therapeutic occurs. In Situation Analysis 34 the doctor asked the older members for their reactions to the introduction of a new member after he had already decided to enlarge the group. Both the observer and the doctor thought in retrospect that this was felt as belittling by the group—as lack of respect for their feelings—and it contributed to the tension and the outbreak of oblique hostility to the doctor when the patient was introduced. The doctor's failure to get either of the central patients to examine their attitudes at the start may also have contributed to the lack of resolution of their subsequent feud.

In Situation Analysis 36 the doctor openly rebuffed the attitudes expressed by the newcomer, and in Situation Analysis 35 he remained silent while the newcomer was put in his place by the old members. In both cases the doctor's lack of open acceptance may have contributed to the newcomer's leaving the group.

On the other hand, in both Situation Analysis 37 and Situation Analysis 29 the newcomer was integrated into the group and therapy was advanced when the doctor indicated acceptance of some of the attitudes involved and aided in their verbalization. In Situation Analysis 37 he helped an old patient see that his behavior toward a new patient was a defense against reactivation of his early feelings of being an outsider, and in Situation Analysis 29 he helped the newcomer see how the situation had mobilized his old conflict over seeking and rejecting help.

Thus, the introduction of a new member into a therapeutic group may be expected to put all the patients under stress. How they react will depend on their own ways of dealing with tension, the group's habitual ways of behaving, and what the doctor does. Sometimes the personalities of the newcomer and of certain old members clash so strongly that the situation does not seem capable of a therapeutic outcome. In such cases the introduction of new members really belongs to the larger problem of group composition.

In view of the emphasis in these groups on intensive examination of highly personal material, it might be expected that once the therapeutic process had really got under way the introduction of a stranger would be more likely to impede than to accelerate it. However, when the newcomer was introduced within the first twenty-three meetings, the doctor was often able to use the situation to promote therapy, if he could indicate his understanding and acceptance of the attitudes that were mobilized and could help the patients examine them.



## CHAPTER XIII

### *Replacement of a Doctor*

---

At the completion of the research phase of our project certain groups were transferred from one doctor to another. Since the new doctor was unknown to the patients, they experienced the change primarily as termination of treatment by the doctor to whom they had grown accustomed. Their reactions were similar to those of patients facing an undesired ending of individual therapy. The knowledge that their doctor was leaving tended to intensify their neurotic problems, especially those concerned with dependency. It likewise intensified their attempts to deal with such problems and thus provided us with an excellent opportunity for studying their reactions. These reactions were, of course, markedly influenced by the psychodynamics of the patients concerned and included open appeals for more help, regression to habitual ways of dealing with anxiety, declarations of independence, and outbreaks of anger toward the doctor. We noted nothing that seemed peculiar to group therapy, except that several patients expressed feelings toward other members of the group that were similar to feelings expressed toward the doctor. At times, too, there seemed to be a heightened tendency for members of a group to draw together and offer one another mutual support in the face of the common problem, but we were not able to determine the conditions under which this occurred. In two of the three groups transferred from one doctor to another, both therapists were present at a few meetings, which led to some interesting transference reactions involving each.

The following condensed account of the first meeting run by the new doctor, after twenty-eight meetings conducted by the old, illustrates many of the phenomena observed when other groups were disbanded or transferred and also calls attention to a common thera-

peutic error—the attempt to get patients to express feelings before they are ready to do so.

This was the twenty-ninth meeting of Dr. N's Group III. The patients (Cann, Goodfriend, Minor, and Stone) had been informed at Meeting 26 that Dr. N was leaving and Dr. A was taking over. Dr. A had sat beside Dr. N at Meetings 27 and 28 while Dr. N ran the group. Today Dr. A was in charge and Dr. N sat at his side.

Stone and Cann were the only patients present as the meeting opened. Stone started by asking Dr. N whether his records could be transferred to Chicago, where he was going the following week to spend the summer, and whether he could continue treatment there. Cann reminded Dr. N that his eligibility for treatment would expire in three months, and he and Stone went on to discuss the difficulties involved in getting jobs and treatment elsewhere. At first Dr. N referred them to Dr. A but desisted when they persisted in ignoring this.

Dr. A pointed out that both men were talking about making changes in therapy and wondered if this had anything to do with Dr. N's leaving. He reminded them that at first they had probably been reluctant to accept Dr. N, but had finally done so, and that now the same situation was repeating itself with him. Perhaps if they could find out what it was about Dr. N that had made it possible for them to accept him, they might find out more readily how they felt about Dr. A. Stone replied with a nervous laugh, "Boy, you're leaving yourself wide open!" and then continued to talk rather vaguely and confusedly about having to get used to a new man. He hinted very circumspectly that he hoped Dr. A would be more directive than Dr. N, who was like a judge, just letting things happen and then commenting on them. Stone seemed quite uncomfortable, as did Cann, who remained silent but squirmed in his chair.

As Stone was speaking Goodfriend came in, and Dr. A recapitulated what had been said. Goodfriend tried to avoid expressing personal feelings on the topic by saying, "Heck, I'm here to get well and one doctor's as good as another," and then generalizing about there always being resistance to change. Dr. A tried to bring the patients back to their feelings about the transfer by asking what there was about Dr. N that overcame resistance. However, Stone merely repeated that they had to get acquainted with a new doctor.

Then Stone and Goodfriend started to argue about a general topic which seemed quite irrelevant, Stone becoming increasingly angry and Goodfriend defensive and apologetic. Meanwhile, Minor arrived and Dr. A again took the opportunity to raise the question about the char-

acteristics which had made it possible for them to get acquainted with Dr. N.

Minor said that some weeks ago, in the doctor's absence, another patient had expressed annoyance that they knew nothing about Dr. N while he knew all about them. Stone named an absent patient, but Cann said that it was he who had made the remark. He liked to think that the doctor was without any troubles. The others disagreed, saying they preferred to think that the doctor had had problems but had found solutions to them, which made him better able to help other people. Minor added that he expected always to have troubles but hoped to learn how to handle them more comfortably. The next argument ended with everybody backing down and more or less apologizing. Then Minor suddenly turned on Goodfriend and said that he seemed nervous—his eye was twitching and he was tapping on the table. Goodfriend, referring apparently to the earlier argument with Stone, said that he got nervous when people were critical. Stone took this as meant for him and replied that there was a difference between subjective and objective criticism, and Goodfriend hastily agreed that Stone's criticisms were not personal. However, Minor promptly turned on Stone and accused him of trying to set other people right all the time. Stone agreed, non-defensively, that this was so.

The meeting ended with Minor's bringing up a personal problem, first addressing Dr. N, then finally definitely turning to Dr. A after seeing that Dr. N did not respond. This concerned his loss of interest in his family and his inability to write to them, in sharp contrast to his lifelong excessive concern about them. Dr. A offered the suggestion that he might be reacting to their persistent refusal to accept his control, as if to say, "If you won't do what I say, to hell with you." He was ignoring them in the way that they had always ignored him. Minor was reluctant to accept this interpretation.

The general tone of the meeting was one of tension and irritability, chiefly directed by the patients toward one another. Although increasingly following Dr. N's cues to direct their remarks to Dr. A, they complied reluctantly and continually looked back at Dr. N. They were made uneasy by Dr. A's repeated attempts to get them to express their feelings about the change in doctors, and repeatedly shied away from this. Cann retreated into restless silence. Minor regressed to an earlier pattern of repeating the doctor's interpretations or questions to patients in a hostile way, as if he were impatient with their failure to get the doctor's point. In this way he seemed to be

trying obliquely to show that he was a better patient and more deserving of the doctor's approval than the others. Goodfriend relapsed into apologies and generalizations. Stone, by contrast, was more openly aggressive and direct than he had been at any other time in treatment, as if trying to show his ability to handle situations and assert his independence.

The most obvious effect of the announcement that a doctor was about to leave a group was an increase in the conflict between the patients' feelings of dependence on the doctor and their desire to emancipate themselves from him. The variations in the way the two sides of this conflict were expressed were as numerous as the patients who experienced it. The need for the doctor might be expressed indirectly, as by a certain patient's moving back to a seat beside the doctor after having moved from this position to the end of the table. The same patient also brought in a form, which he asked the doctor to help him fill out, although he could easily have done it himself. At the other extreme a patient quite openly described his feeling of being deserted by the doctor and requested individual therapy in addition to group therapy, so that he could work this through. He added that he had to resolve his intense, mixed feelings toward the doctor before the latter left, as if he had to convince himself that he no longer needed the doctor before the doctor deserted him. Many patients openly expressed their reluctance to start with a new doctor.

The attempt to achieve independence was sometimes manifested simply by staying away, often with hostile intent. One patient, for example, said that he had gone to the movies instead of the group meeting because he thought the movies would do him more good. Such direct attempts to prove that therapy was no longer needed were usually followed by an exacerbation of symptoms or regression to highly neurotic behavior when the patient returned. Patients were also apt to recite how much they had gained from therapy as if to reassure themselves in regard to their improvement, as well as to make a good final impression on the doctor. Or patients might behave in a more mature, self-reliant way, as did Stone in the meeting described above.

Like all conflict situations, this one tended to be accompanied by



tension, anger against the doctor responsible for it, and regression to earlier patterns in an attempt to deal with it. Increased tension and more or less disguised anger at the doctor for having failed or deserted the group were frequently noticed. In the meeting just described Stone hinted at his dissatisfaction with the doctor, not on the basis of his leaving, but because he had not been directive enough. A patient in another group talked of his persistent distrust of the doctor, and his feeling that the doctor wasn't listening attentively. A second patient thought that by leaving the group the doctor was trying to hint to the patients that he was tired of them, or that this was a way of easing them out of treatment. A third patient characterized the atmosphere of the doctor's last meeting as like that of a wake. Regressive behavior commonly occurred. In the meeting described, Goodfriend and Minor both went back to earlier ways of behaving. A patient in another group returned to his original, but long since abandoned, insistence that he was physically ill.

On the other hand, the knowledge that the doctor was leaving caused some patients to bring up painful material which they had hitherto withheld. This may have had some rational basis, such as the desire to make full use of the old doctor before he left, since he obviously knew more about the patients than the new one and therefore could probably help them more. However, it may also have had an irrational motivation, such as the desire to complete treatment and leave the doctor before the doctor left them. An attempt to brief the new doctor on the important issues as rapidly as possible may also have been involved.

The knowledge that the doctor was leaving seemed repeatedly to stimulate patients to discuss problems in their personal lives that were similar to issues raised by his departure. These centered around loss or separation from people and dependence and independence. Thus, in one group, one patient said that he had been thinking about the recent death of a brother-in-law. This man had been sick for two years and his death had been expected momentarily, but the patient had not mentioned it before. Another patient said that he had become preoccupied again with the tumultuous emotions he had felt on the death of his father many years previously, the central problem being

that now that his father was dead he could never tell the father what he had really thought of him, because one could have only good thoughts about the dead. This patient then immediately went on to talk about still being concerned about his ability to hold a job.

Discussion of jobs, becoming self-supporting, supporting one's wife, and so on, frequently came up in meetings when the doctor was about to leave—apparently representing one aspect of the patients' concern over the issue of emotional independence. Minor's concern over no longer feeling responsible for his family (which he had not mentioned before) may have implied a reproach to the departing doctor for neglecting his responsibility to his patients. Another patient, in the first meeting with the new doctor, told at length of his determination never to become obligated to anyone, which he had not mentioned before. This seemed possibly to be an indirect expression of regret that he had permitted himself to become dependent on the previous doctor.

The simultaneous presence of two doctors, a new and an old one, stimulated reactions of a very similar nature in two patients in different groups, as shown in the following examples.

Meeting 96 of Dr. N's Group II was the first meeting run by the new doctor as Dr. N sat by. Bly, the patient who had been most dependent on Dr. N and most in conflict about him, started rather belligerently to cross-question the new doctor about what the latter knew and what his attitude was. After expressing his distrust, Bly said that the new doctor reminded him of a boy at school who had received exactly the same marks as Bly had but who, because his father was dead, had got the scholarship that both boys were competing for. Bly deeply resented this. At about this time he had spoken in individual sessions of his strong need to control the group. It seemed clear that he was indirectly implying that he was better qualified to run the group than the new doctor was and that he should have been given the job. He associated Dr. N's departure with the death of the other boy's father; his leaving the group was equivalent to dying because Bly did not know where he was going and would lose contact with him.

In Meeting 27 of Dr. N's Group III Cann, whose inadequate father had died when he was a child and whose mother had always expected him to act responsibly while she indulged his brother, became un-

usually tense the first time the new doctor attended the group. He cross-questioned other patients more than formerly and seemed to show a good deal of irritation when they would not accept his interpretations. At the end of the meeting he said that he had probably been trying to take the doctor's role. Dr. N asked what he thought of, and immediately he said he thought of his mother. Another patient asked if the presence of the new doctor had anything to do with it, and the meeting ended with Cann puzzling over this.

In Meeting 28 he brought up the topic again and mentioned that at one point in the previous meeting he had had a feeling of irritation with Dr. N because he thought the doctor had missed a point with another patient. Dr. N raised the question whether Cann thought him incompetent, but the patient backed away from this and instead talked about his efforts to dominate his class at school. It seemed to him to be related to his mother's trying to make him play the role of the father. He then said that he somehow seemed to identify the new doctor with the brother against whom he had had a grudge. Thus the introduction of the new doctor revived a childhood feeling based on resentment at being called upon to play a paternal role, through the incompetence and death of his father. He projected this feeling in the group situation by accusing Dr. N (the dying father) of incompetence and trying to show how much more competent he, the patient, was than either of the doctors (his father and his brother).

It should be pointed out that a change of doctors need not be harmful to a group. Some patients may find that the presence of a new doctor allows them to discuss feelings toward the former one which they could not have expressed before. Others may find it easier to express certain feelings to the new doctor because of his different personality attributes. Thus, in the example given in Chapter v (pp. 133 f.), Stern was able to reveal sexual material to Dr. N which he had concealed from his former doctor for fear of losing the latter's respect. The ways in which the introduction of a temporary or permanent replacement for the doctor may be used to stimulate therapy need further investigation.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

The occasion of a doctor's leaving a group appears to stimulate feelings which are concerned with the patients' dependency needs and their

struggle for emotional emancipation. It can thus afford an excellent opportunity for helping patients express and analyze their feelings. We observed that once the members of a group know that a new doctor is to take charge they soon begin to transfer their allegiance to him. There is an advantage, however, in both doctors' being present for a time. It seems to stimulate the bringing out of new material, motivated apparently by the desire either to get full value from the old doctor before he leaves or to familiarize the new doctor as rapidly as possible with their major problems.

The presence of a new doctor may elicit certain transference reactions in relation to sibling rivalries which did not appear before. It may also enable patients to express attitudes toward the former doctor (after he has left), which they were unable to express directly, and to express emotions which they thought were unacceptable to him. Thus, under certain circumstances, there may be value in introducing a new doctor, even though it is not required by circumstances.



## CHAPTER XIV

### *Relations between Individual and Group Therapy*

---

A LACK of confidence in their ability to do group therapy, born of lack of experience, led all the doctors at first to see patients in regularly scheduled individual sessions at least as often as in group sessions. As their experience increased, they reported more confidence in their ability to utilize the group and increased belief in its effectiveness. One doctor eventually started groups without regularly scheduled individual sessions. He found it advisable, however, to keep half an hour free after each group meeting, when patients could speak to him alone if they wished. He always assented to a patient's request to be seen alone for a full hour and took the initiative in arranging for an individual interview when it seemed indicated. Actually, after the initial orienting interviews about half the patients had no individual sessions and none were seen more than five times individually, nor did patients often stay behind for more than a brief word after a group meeting.

Our experience was too limited to permit any conclusion as to the optimal ratio of individual and group sessions. It may be said, however, that the improvement rate of patients receiving group treatment almost exclusively did not seem to differ significantly from that of patients receiving regular individual sessions.\*

The relation of group and individual sessions and their relative importance were frequently discussed in seminars. The experiences of the different doctors varied widely. What was brought up in the two types of sessions and how each influenced the other seemed to depend

\*See Chapter III.

to a large extent on the attitudes and predilections of the doctor, which we were not able to define. The following comments on individual and group sessions are therefore only tentative.

The extent to which individual interviews were really needed with many patients remains an open question. The opportunity to see the doctor regularly in individual sessions sometimes seemed to drain off material from the group meetings. For example, during a period when Dr. N had to cancel the individual sessions scheduled for the members of his Group 1, material was brought out in group meetings which had previously been reserved for the doctor's ear only. This cancellation also stimulated resentment against him and caused a rise in group tension which was therapeutically useful.

It was noted that some of the patients in the groups which were conducted without supplementary individual sessions made excuses to see the doctor alone after the group meetings. These special bids for attention often constituted useful material for analysis. For example, it was observed in the early stage of one group that a certain patient always managed to find a pretext for staying after the others had left—usually to report a symptom. This proved to be a manifestation of his competitiveness for the attention of authority figures, which he also showed in his classes. When he gained insight into this pattern, not only did it practically disappear, but he was more able to use the time of the meetings to discuss matters which previously he had seemed to be withholding in the half-formed hope of being able to talk them over privately with the doctor at the end.

Leaving the scheduling of individual interviews to the patient presented difficulties in two directions. (1) Some patients were skillful at persuading the doctor to see them alone when they didn't really need it. Such interviews seldom were of therapeutic benefit because the other group members usually became aware of the patient's maneuver and resented it. This added to the patient's uneasiness in later group meetings. Moreover, the patient himself was apt to feel humiliated because he had shown excessive dependence on the doctor. On the other hand, if a patient called for an individual session because of a transient upset but found, as the doctor had suggested, that he could handle the difficulty himself, his self-confidence was likely to

be strengthened. Often such a patient would ask for an individual session early in the group meeting and then, later in the same session, would bring up the problem which he had felt he could not discuss in the presence of other patients. (2) Conversely, a patient who would really have benefited from an individual session was sometimes inhibited from requesting it by unfounded fear of the resentment of the other group members, or the belief that he was imposing on the doctor. Often the other members clearly perceived the desirability of individual attention for such a patient and were more than willing for him to have it. As an aid in escaping both these difficulties, when a patient asked for an individual session, his request was discussed in the group, and when the doctor decided that an individual session was desirable for a certain patient, he always told the group. In this way attitudes which might have proved too disturbing were kept in the open.

When groups were conducted without regular individual therapy there seemed to be several main indications for special individual sessions. If a patient was in the grip of acute anxiety or other emotional disturbance which hindered his working through the problem, an individual session might give him additional support. Or if a patient was under great pressure to pour out personal material which had so little meaning for the others that their presence had an inhibitory effect, an individual interview might make it easier for him to talk about it. An individual session might also be useful if a patient was hindered in working through some problem by another patient's need to hold the floor, or if a patient expressed attitudes, such as intense hostility, which seemed to threaten his relation to the others to an insupportable degree. Finally, of course, the doctor acceded to patients' requests to see them with their wives in individual sessions.

Some patients tended to save for individual sessions things which they perceived as humiliating to themselves, or to distort what they said in the group. One patient told the group how he had given up a girl with whom he had had intercourse in order to go with a more attractive girl whom he could not even kiss. When a patient who was antagonistic toward him suggested that he didn't want the girl for herself but to impress other people with, he denied this and insisted

that he had been just as happy sitting alone in a room with the popular girl. In individual therapy he had said that he went out with this girl solely because he wanted other men to see him with her.

Some patients seemed reluctant to make remarks in the group that they feared might offend or alienate the others. One patient, for example, frequently commented in individual therapy on the "weak and pathetic" appearance of a second and expressed his anger at a third. He never expressed either in the group. Another patient finally told in individual sessions that he resented his fellow group members as rivals for what he considered to be his position as the doctor's favorite. He could not express these feelings in the group until he was "ready to graduate" from it.

Friendly feelings seemed even more difficult to express, often because of the implications of homosexuality. It took a year and a half in one group before two patients were finally able to express their mutual attraction and to discuss the possibility of a homosexual element in it, although one had frequently discussed it in private sessions.

The difference between the kinds of material brought out and the attitudes displayed in group and individual sessions depended not only on the patients but also on the ideas which the doctors held with respect to the function of group sessions, the kinds of material they preferred to have brought out or withheld, and the attitudes they fostered or discouraged, consciously or not (see Chapter xv). Doctors often found it useful to refer in individual sessions to material that had been brought out in the group and vice versa, but this was not without its dangers. For example, one patient had experienced a severe shock in the group when sharp questioning by another patient almost brought out the fact that he was Jewish, which he had hoped to conceal. This was used in individual interviews to help him see both the depths of his conflict and the strength of his need to seek approval in all social situations. The doctor's calling attention in the group to something a patient had said in individual therapy had many repercussions, some of them therapeutic, some of them not, depending on whether the remark was regarded as a breach of confidence. More subtly, reference to what went on in an individual session with a patient occasionally aroused jealousy in another because of the implication



that the first patient was closer to the doctor, as in the following example.\* This jealousy, of course, might have been a useful attitude to study.

In a private interview with Dr. L between the first and second group meetings Charles had expressed irritation at himself for having been so withdrawn at Meeting 1.

Early in Meeting 2, when Dr. L asked, "Do any of you have any problems you want to bring up?" Throck asked what kind of problems and then emphasized his question by stating that he did not know what he should bring up. Charles laughed at this and said that they ought to bring up the kind of things they brought up in individual sessions. Thereafter, without talking of himself, Charles occasionally complimented, advised, or criticized other patients in a way that indicated his identification with the doctor. Near the end of the session Dr. L reminded Charles that he had mentioned certain feelings after the last meeting. Dr. L referred, of course, to feelings Charles had expressed in the private interview. Charles answered briefly that last time he had been afraid to say anything. Throck said that he himself had talked too much this week again but was going to "stay shut" next week and see what happened. Charles then brought out for the first time personal material in saying that his own trouble went back to keeping in the background while his twin brother advanced to greet his father. Throck asked sarcastically if this discovery had made his pains disappear. Charles added that he had been angry with himself last week after the meeting for having said nothing. Freedman then said that he was afraid when he talked with others. Throck: "Not here, you aren't." Freedman, laughing and looking at the doctor, said that he always used to be afraid but now was just annoyed. Throck then spoke to Dr. L about a person with heart trouble whom they alone knew. Charles asked Throck about this person, but Throck, evading the question, went into a typical monologue that got nowhere. Earlier in the meeting the doctor had wanted to bring up the patients' fear of talking in the group and used the casual reference to Charles' feelings as a way of doing this. By leaving the choice to him as to whether he would be specific, the doctor did not put undue pressure on him to reveal the content of the interview. Charles brought out his fear of talking in the group, and this stimulated expression of similar feelings from Freedman and Throck. To this extent the maneuver was useful in spite of Throck's jealousy, which led him to assert a special claim on the doctor.

\*Cf. Situation Analysis 10.

Throck opened Meeting 3 by asking Dr. L for some papers they had discussed in a private session.

An attempt by the doctor to get a patient to talk in the group about difficulties he had discussed in private sessions, while it might meet with strong resistance, might still cause the patient to talk in such a way as to enable other patients to relate to him more usefully, as in the following situation analyses.

### *Situation Analysis 38*

#### *DR. L'S GROUP, Meeting 22*

PRESENT: Hamling, Charles, and Bassom

SETTING: Hamling had taken the floor only once before this meeting to talk largely about his job, seeking sympathy for his hard luck. This occurred after he had been away from the group for a month, and the group had indicated that he was welcome on his return.

In Meeting 22 the discussion started off with Charles questioning Hamling about his marital situation. Hamling said that talking about your troubles was supposed to make them disappear but it hadn't happened this way with him yet.

EVENT: Dr. L said something about bringing up subjects for discussion that Hamling didn't like to talk about, thus referring obliquely to what Hamling had talked about in individual sessions, but not in the group.

EFFECTS: Hamling brought out that he didn't like to talk in the group about anything that he considered detrimental to himself. This led to discussion of what he considered detrimental, which proved to include the subjects he reserved for individual sessions—sexual and childhood experiences and things that he didn't like about himself. When questioned about the last he referred only to such externals as his lack of education and experience, but even this gave the other members of the group a lead in relating to him in an attempt to examine his defenses. They brought out the discrepancy between Hamling's concept of his situation and reality, by showing how it would be possible for him to acquire an education. Bassom, an accountant, was able to carry this a step further and point out that lack of education could not really be the problem because acquiring his education hadn't changed his problems, which were similar to Hamling's.

DISCUSSION: Hamling resisted talking about himself by stating that it didn't help. Dr. L tackled this resistance by indirectly indicating that Hamling did not bring up for discussion in the group material which he had mentioned in individual sessions. In response to this

Hamling's resistance took another form. He mentioned some things about himself but not those which he had not wanted to talk about. He implicitly appealed to the group for sympathy for his impossible lot, which he felt he was incapable of remedying. But he did give the group something to link to, and members showed that he could do something about his situation if he wanted to.

**TENTATIVE DEDUCTION:** When a patient fails to make progress in a group, it may be helpful to call attention to his resistance by referring to the fact that he brings up things in individual sessions but not in the group. This may spur him into producing something which makes it possible for other patients to relate to him.

We sometimes found it useful to point out a discrepancy between what had occurred in an individual session and the patient's report of it in the group, as a way of calling the patient's attention to an important attitude.

For example, during a period when there was much discussion about taking responsibility oneself or blaming others, a patient in reporting a decision not to marry his girl, said that the doctor had told him not to in an individual session. He said that this had entirely changed his feelings toward her—from being in love he now felt completely indifferent. The doctor reminded him in a friendly way that in the interview referred to it was the patient who had first expressed doubts about marrying—the doctor had concurred only to the extent of agreeing that in such important matters it was wise to move slowly. The patient at once agreed that he himself did not think he was ready to marry and also recognized that his distorted report of the occurrence was an example of his tendency to shift responsibility to others.\*

The following is a striking example of the value of bringing to the group material from individual interviews.

A patient felt strong, neurotically motivated hostility toward his wife, which he did not directly express to her. Instead, he fantasied disgracing her by making known their premarital intercourse (the first for both of them). He had talked about this to the doctor privately, without change in his fantasy. When the time seemed ripe, the doctor asked him in the group whether he was ready to give up his secret weapon over his wife. With much hesitation he told the group about it and was dumbfounded that none of the members were critical of her. One even said he should be grateful to her for "making a man of

\*See Chapter VI, p. 157.

him." Following this, he was able for the first time to tell his wife of his hidden anger at her (which he thought he had successfully concealed). She indicated her awareness of it by saying that she had been afraid of him. After this the patient expressed his anger to her directly, but its force was much diminished and their relationship became much more relaxed and genuinely friendly. The doctor's failure to agree that the premarital act disgraced his wife was not effective. It took the reality of the group's approval of her to change his attitude.

Similarly, in the following situation analysis a patient reached an insight he had failed to achieve in individual sessions by discussing the same attitude in the group at the doctor's suggestion.

### *Situation Analysis 39*

#### **DR. N'S GROUP I, Meeting 72**

**PRESENT:** Coombs, Trippitt, Milton, Gugis, and Eubank

**SETTING:** Mutual hostility among members of the group had been expressed and freely discussed with the expectancy that this would result in therapeutic movement. On the whole the patients were comfortable with the doctor. Coombs, the central patient, was an ambulatory schizophrenic, a man of great promise who had interrupted his education, left his family, and drifted downward economically until at this time he was unemployed. He characteristically brought to the group a great deal of very emotional material in a lurid and unclear way. He had told of fantasies illustrating intense jealousy of his father and brother for taking his mother from him but had not modified his behavior or attitudes. His participation was compulsive, and when he presented this kind of material, he had generally come to the group in a highly disturbed state. The relationship of his disturbance to the group situation was difficult to discover if present. He had acted like a meek individual who always did what he was told to do, but in the group had been showing increasing freedom in expressing his resentment at those who acted superior to him. He also showed tendencies at times to impose his will on the group. Coombs was compliant in bringing out the kind of material Dr. N asked for and talking when the doctor expected him to.

Supported by other patients, Coombs had attacked Trippitt for his intellectuality, and as a result Trippitt had abandoned his intellectuality in the group to a great extent.\* Coombs had continued to attack

\*See Situation Analysis 33.



Trippitt, partially aware that he was using him as a surrogate for his brother. Coombs' relationships with other members of the group were less hostile than with Trippitt, but he had expressed no positive feelings.

In the individual interview which preceded Meeting 72, the doctor began to examine with Coombs why he remained sick despite the insight he had gained, and Coombs began to see that he was remaining as he was in order to spite his family.

In Meeting 72 he started by trying to baffle the doctor and the group with a question as to what he had talked about in the individual interview which began with "a." The doctor could not supply the word immediately, and Coombs described a lurid dream in which there was an explosion. He then remembered that the word was "anger." His discussion of his feelings continued to be inconclusive and confusing to himself and to the group. He began to trail off, and Trippitt said that he would like to talk about his own problem if Coombs had got what he wanted out of this. Coombs said it still wasn't clear to him.

EVENT: Dr. N recalled that in the individual interview Coombs had said that the group was his family and suggested that Coombs tell the group what he thought of them. Coombs explained that the group was his family: Trippitt was his brother John, whom he despised, and he expected that everyone in the group would defend him. The doctor was perhaps his father—it wasn't quite clear to Coombs whom he represented. Eubank was his brother Andrew. Coombs felt that if he expressed himself, the group would put him out for annoying John (i.e., Trippitt). The doctor continued to bring Coombs back to his fantasy of being forced out of the group and his feelings about it.

EFFECTS: Coombs finally said that, although it might be funny, he was going to admit that he felt the group couldn't do without him. When the doctor asked if he had the same feelings toward his family, he brought out that he felt that his father had died because he himself had left home; the family's stupidity, unaided by Coombs' intelligence, was the cause of his father's death. He never had thought until now how the family depended on him for salvation. Later Coombs said that he was keeping alive the feeling that the group wanted to cast him out and added that he probably did so because he wanted to be cast out.

As Coombs brought out these feelings, his tension diminished and his speech became completely coherent. The group heard him out but went on to other concerns when he had finished.

DISCUSSION: The doctor's calling attention in the group at an appro-

priate time to Coombs' association of the group with his family, which he had discussed in individual sessions, led Coombs to report it in the group. This led him to analyze his feelings toward the group while in the midst of it instead of retrospectively. He was able to come to a new insight which had not been gained through reviewing the same material in the preceding individual session—his fear that his family would cast him out concealed a wish that they would do so. They would be destroyed without his care, and he would be revenged on them through their own act rather than his.

The doctor felt safe in bringing out Coombs' displacement of his feelings toward his family on the group because the group was accustomed to dealing with hostility.

TENTATIVE DEDUCTION: In this situation the analysis of an attitude to the group as it was being experienced was more effective than a similar attempt made retrospectively in an individual session.

That relations between group and individual sessions can be extremely complex is shown by the pitfall into which an inexperienced doctor fell. In an individual session with Patient A he repeated something quite innocuous that Patient B had told him privately. In the next group session Patient A revealed that he knew this, causing Patient B, who was very suspicious, to react violently against the doctor and temporarily shaking the confidence of all the members in the doctor.

### SUMMARY AND IMPLICATIONS FOR THERAPY

The need for individual sessions at regular intervals or on special indication, their advantages and drawbacks, and how the attitudes shown and the material produced in them differed from those of group meetings seemed to depend to a large extent on the attitudes and predilections of the doctor. In groups without concomitant individual therapy, such sessions seemed helpful in aiding a patient to work through either acute emotional disturbances which seemed to threaten his relations to the others in the group to an insupportable degree or personal material which the patient was under great pressure to bring out but which did not seem to apply to the others.

In referring at a group meeting to an occurrence of an individual session the doctor should keep in mind possible repercussions in the

form of jealousy over individual attention or loss of faith in his ability to keep confidences, and he should guide himself accordingly. The potentially bad effects of using material from an individual session in a group meeting were minimized by asking the patient's permission first—or still better by leading the discussion in such a way that the patient himself brought the matter up. Patients may reach important new insights by bringing up in the group at the doctor's instigation something which they have discussed in individual sessions.

## CHAPTER XV

### *Doctors' Characteristics in Relation to Therapy*

---

It has been taken for granted that the doctor's personality and problems influence his style of therapy. There are, however, almost no objective observations on this subject in the literature with the exception of a recent article by Mann and his co-workers.<sup>1</sup> Because of our use of observers and the frequent conferences held between the clinical and research divisions of our staff, we had an unusual opportunity for studying the effect of the doctors' personal characteristics on the problems which they encountered in working with groups. Since all our doctors were trying to do analytically oriented therapy, differences in approach and their effects on patients became apparent. In fact, we discovered that the doctor's personality was fully as important to therapy as the composition of the group.

This conclusion has been implied in earlier chapters. In the present chapter we have selected for more detailed discussion the relation of the doctors' characteristics and technical training to the problems they encountered. In conclusion we have summarized for each doctor the more salient aspects, as they seemed to relate to therapy.

#### COMMON PROBLEMS

It was to be expected that the doctors in the group therapy project would have many of the same difficulties that they had with individual therapy as well as the special problems arising from the group setting, the type of leadership involved, and the presence of the observer.\* In addition, ambivalence toward group therapy seemed at

\*For problems in the relationship between the doctor and the observer, see Chapter II.



times to play a part with a few of the doctors, although all had volunteered to participate. Recognizing the difficulties inherent in group therapy for some personalities, the senior investigators tried not to put pressure on anyone to participate. It may be, however, that unconscious pressure was exerted in certain cases. No one who volunteered was rejected.

### *Problems of Leadership*

It was expected that the type of leadership exerted by the doctor would depend on his own personality, experience, and theoretical conceptions of group therapy. The literature gives many examples of the widely different concepts of leadership in group therapy, ranging from the "free" groups of Bion and Slavson to the lecture-discussion groups common during the war and still prevalent. But whatever his approach, the doctor must assume leadership of the group. His training gives him a clearer concept than the patients have of how to accomplish the therapeutic purpose; his knowledge enables him to set up realistic long-term and immediate goals for the group, to observe objectively the relations of the patients to one another and to him and to study these patterns as well as the psychodynamics of the individual patients. With this in mind, he listens to what is going on, decides whether, in order to achieve his goals, it is necessary to say anything, and if so, to whom and in what way he should say it. He sets the mores of the group—what can and cannot be done, and to some extent, the way in which it can be done. Thus, by virtue of his special training, the responsibilities of his therapeutic relationship with the patients, and the prestige and authority with which they invest him, his role of leadership is inevitable. He cannot help being the most influential single individual in the group, whether he speaks or remains silent and whether he desires to be so or not.

The need to be the active leader most or all the time was important to some of our doctors. They might make a conscious effort to permit the patients to take initiative in spite of their own need, or they might unconsciously try to prevent it. Therapy suffered in either case. Other doctors became aware that their marked passivity was an over-reaction to the guilt they felt about their desire to lead. In one group the

doctor felt a strong desire to be "one of the boys" rather than a therapist with special responsibility for the group.

Being part of a group as a leader or even as a member sometimes caused more anxiety than a doctor could manage. One doctor who had been an overprotected only child and had never been part of any group of peers of his own sex when he was young was made anxious when the patients began to form a real group. He said that he broke it up because it was not good for the patients—that is, if the patients became comfortable in their relations to one another there would be no tensions to analyze. (This statement is true up to a point but overlooks the fact that patients need group support before they can face their tensions.) Later he realized that they made him feel left out, as he had felt as a child. He found group therapy very difficult and was not successful at it.

In group therapy there is the opportunity and sometimes the temptation for an insecure doctor to lean on a patient—usually one who verbalizes "insight" readily—and to encourage this patient's leadership instead of analyzing his behavior and inviting others to participate. He overlooks what assumption of leadership means to the patient as well as to the doctor and the rest of the group and rationalizes his own attitude as an encouragement of the "democratic" process of group therapy.

Certain doctors who apparently had to feel that they were controlling or manipulating the group in some way thought of themselves as benevolent. The urge for leadership did not always seem to stem from a desire for power or position but sometimes seemed to come from such a great need to feel useful that the doctor had to be directly active in the cause of getting patients well; unconsciously he would avoid giving the patients an opportunity to help themselves and one another, or felt frustrated if they did.

One doctor who was a kind, protective, fatherly person expressed his fear of not being able to "control" the group if five or more were present. He watched them with considerable tension to see if they were working well together or if his therapy was adequate to the situation. He worried about keeping each patient in mind and keeping his therapy at the level of intensity that he would have tried to

maintain if the group meeting had been an individual session. He became anxious when two patients became angry with each other, as it did not fit his picture of benevolence. Another doctor said he was uncomfortable with more than two patients; he felt that it was easier to "control" the smaller number and was surer of his therapy. Several doctors were made acutely anxious by silences because they did not know what was going on in the patients' minds and therefore felt unable to help them. When therapy did not seem to be progressing, these doctors would become anxious, irritated, or punitive, and therapy would be inhibited further. Sometimes anxiety would cause a doctor to attack his patients' defenses before they were able to face the issues, thus producing too great anxiety in the patients. This is illustrated in the section on patients who dropped out of groups.\*

### *Problems of Hostility*

It is often easier for a patient to express criticism and hostility in a group than in individual treatment but harder for the doctor to take. Two or more patients can gang up on the doctor. Criticism from a patient shows him up before several persons rather than just one. Some doctors were unable to accept criticism from a patient, whether or not it was hostile, and would not try to understand the meaning of anger directed toward them, as it seemed to them to threaten their position, or rather their picture of it. One doctor found it extremely difficult to recognize hostility in the group, and, when its presence was forced on him, maneuvered to prevent its further development, although intellectually he was quite aware of its importance. On an occasion when a certain patient tried to express strong feelings in a group in which the doctor showed apprehension by his facial expression and body posture, the rest promptly blocked him, perhaps because they felt they had to protect the doctor. Conversely other doctors, particularly two who were treating psychotics, encouraged expression of hostility among members and toward themselves to a degree which disrupted the group.

Even though unexpressed, the doctor's attitude toward hostility seemed to be sensed by the patients, who reflected it in their behavior.

\*See Chapter iv.

In one group of schizophrenics, for example, the patients exploited the fact that the doctor was made acutely uneasy by silences. In examining his own attitudes the doctor recognized that when angry his father had always refused to speak to him. In another group in which there seemed to be little therapeutic progress for a time, hostile feelings had been freely expressed at a superficial level. The doctor had said that he considered emotional release to be one of the most important experiences of group therapy, but he was also aware of his fear of it. He showed his ambivalence by calling for premature examination of feelings or by making intellectual generalizations. Expression of emotion seemed to be motivated by a desire to please the doctor (as the patients explicitly stated at times) but was generally not accompanied by associations to the patients' feelings or by exploration of the patients' problems in relation to their feelings.

In still another group the obvious absence of direct hostility to the doctor and the abrupt aborting of indirect attempts to express hostility were apparent. Although the doctor appeared to be very permissive, there must have been something in his attitude which prevented expression of truly hostile feelings toward him. The patients apparently felt an obligation to live up to the doctor's expectancy of an atmosphere of freedom and good fellowship. There were, however, oblique sallies such as the following:

*Meeting 26 (beginning):* A patient remarked, "Let's talk about you for a change." Doctor: "Why do you say that?" Patient, laughing self-consciously: "Just for a joke." Doctor: "What do you want to know?" Patient does not reply. Subject is changed.

*Meeting 27:* Caster and Rice wondered about women marrying psychiatrists. Cole: "Aren't psychiatrists human?" Caster: "I don't know." Doctor: "Why do you say that? Let's discuss it." Caster: "Why are you single?" Doctor: "Perhaps it's because I can't make up my mind." Caster (who was single): "Touché." Caster then asked another patient a question, changing the subject.

### *Other Subjective Reactions*

Problems and feelings other than those connected with hostility were of course brought out in the group or through the personalities of patients. They sometimes caused subjective reactions, of which the



doctor might or might not be conscious, with resulting blind spots, insensitivity, or hypersensitivity.

This was especially true when the doctor's neurotic reactions were the same as those of patients in the group, since his feelings might then be intensified by the number of people all reacting the same way. Some doctors also tended to agree with the majority of the group, to be protective toward a particular patient, or to have other special attitudes toward him. When this occurred, it was obvious to the group. Other doctors were afraid of positive feelings toward themselves or between patients and would try to prevent their development and expression, or, when they were apparent, would not analyze the implications. To avoid open expression, a doctor would often unconsciously focus on another patient, change the subject, or call on the patient who was speaking to examine his feelings before he was ready to.

The relative extent to which sexual material was discussed in group and individual sessions seemed to depend in some cases on the doctor's attitude. One doctor stated that "natural reticence" would make a patient prefer to discuss such matters privately and his patients tended not to discuss sex in the group. Another seemed to encourage and enjoy discussion of sexual activity and his group responded accordingly, but his conflicts about marriage led him unconsciously to foster sadistic behavior toward a patient who was about to marry. Still another doctor said that at one time he had had a conflict over homosexual problems. This was probably reflected in his attitude toward two patients in the group, as he felt antagonistic toward the overt homosexual and protective toward the latent homosexual, whose verbal facility he mistook for therapeutic progress. A doctor who was inclined to be something of an intellectual snob tended to ignore the duller patients. An Irish Catholic doctor only retrospectively realized that his hypersensitiveness about discrimination against his own people was the reason why he had stopped the group's discussion of a problem of a patient over his Jewishness by saying, "We are all Americans here."

In composing groups some doctors appeared to be influenced by their reactions to certain types of patients. As one doctor noted, he became aware that he tended to put those patients in his group about

whom he had the least anxiety and he recognized that the anxiety he felt about certain patients was related to his own difficulties.

### DIFFICULTIES DUE TO INEXPERIENCE

Not all the difficulties of group therapy were due to the doctor's personal problems. Some arose out of previous experience or lack of it. It may be of interest to note in this connection that the older, more experienced doctors tended to concentrate on individual patients and to be most protective of them, perhaps because of longer experience in individual therapy.

Many of our doctors felt that group therapy was particularly difficult because they thought they should try to understand what was going on in each individual at all times. In addition they had not been trained to perceive group interaction—or, as one doctor put it, "What the group as a whole was up to, if anything." Similarly, a doctor might become anxious when a number of patients were trying to talk about different topics and he did not know whom to encourage or to whom to give attention. In time, however, he learned that seemingly diverse topics are often related and that the common factor will become apparent if he lets the patients continue. He also learned that patients are helped by many things of which he is not aware. For example, a patient who was relatively silent during group meetings, but who subsequently showed a marked benefit from therapy, said that one of the most helpful occurrences during his treatment had been the doctor's failure to give him an expected rebuke after a deliberate absence. This proved to him that the doctor was interested only in helping him. The patient had a very moralistic authoritarian father, and this experience with the doctor, although not analyzed, seemed to have been a corrective emotional experience. The doctor, who was a very permissive person, had been unaware of the patient's fear or of his own lack of reaction.

The effect of previous experience in group therapy in which group dynamics were ignored may be illustrated by a doctor who reported that his "previous technique in group therapy had been to promote a stilted discussion around a set topic, calling upon patients in rota-

tion," in the hope of getting them to "pour out the material" that would lead to recovery. As his style was rigid and didactic, the patients did not respond favorably, and he himself felt uncomfortable in such an artificial situation. Also, because of the almost constant discussion of ideas about therapy which went on in the staff conferences, some of the doctors felt constrained to use techniques not congenial to them, because of their undue respect for the proponents of these techniques and their own lack of confidence. Initially, this probably resulted in temporary failures and considerable insecurity. For example, when the paternalistic doctor mentioned above tried to be non-directive there occurred the only two demonstrations of physical violence which broke out during the course of our experiment. Another doctor, in an attempt to get his patients to relate to one another instead of to him, assumed a formal and remote manner that was quite contrary to his personality. A third, mentioned above as being afraid of hostility, tried to foster its unlimited expression without regard to whether it was therapeutically appropriate in the particular situation; a fourth encouraged the expression of hostility and then did not know how to handle it. In contrast, one of the more experienced doctors waited until he had clarified his own ideas as to how he wanted to conduct a group. He was then able to take charge with relative self-assurance. In time, all the doctors became confident enough to accept the importance of being themselves. They thus achieved increased freedom to observe and analyze what was going on in the group, with the result that they were able to act appropriately instead of merely carrying out certain techniques or assuming certain attitudes.

#### CHARACTERISTICS OF INDIVIDUAL DOCTORS

The following descriptions summarize the salient characteristics of each doctor as observed and discussed with him in relation to what went on in his groups. Because the doctors discussed their outstanding problems rather than their successes, these descriptions emphasize the difficulties encountered. They in nowise present a rounded picture. They do, however, show how the atmosphere differed from group to group, even though all the doctors were trying to conduct analytically oriented group therapy. The reader may find these useful in connection

with the description of therapy and the situation analyses in the preceding chapters. Data were available only for those doctors who treated groups at the Mental Hygiene Clinic.

Dr. K stated that he feared his own need to control and therefore bent over backward in an effort not to do so. For a long time his interventions were halting and timid and he was the most passive of the doctors. He frequently sat hunched up with an impassive expression. Coming from an economically depressed minority group, he was sensitive to discussions of minority problems and tended to divert them.

Although an intellectual himself, he had a mixed feeling toward intellectual patients. He welcomed them as helpers who would see things that he missed but also felt that they were competing with him. He believed that he should facilitate expression of hostility as part of therapy (possibly in line with his masochistic trend) but tended to forestall the development of tension in the group by calling for analysis of what was going on before the patients' feelings had had a chance to develop fully. At one point a patient criticized him severely for impeding spontaneity. In his group there was much discussion of feelings and attitudes but with relatively little analysis or resolution of problems; eventually the members showed considerable rivalry.

This doctor expressed some of his feelings and attitudes and their relation to therapy so clearly that we quote him:

"When I began group therapy, and for at least a few months thereafter, I was in a damned nearly catatonic state during the sessions—unable to move my hands up from my lap onto the table lest they shake uncontrollably, for instance, and too anxious to make *any* comments in some of the meetings. My thoughts, before and during the sessions, dwelt upon the likelihood of there ensuing a maelstrom of hopelessly complicated and uncontrollable hostile and frightened feelings from the patients, or upon showing excessive emotion in the group."

Later he said, "I still feel *much* more anxious in group therapy than in individual therapy. But I have been increasingly and steadily convinced that actually, for a well-analyzed person, group therapy might be even more comfortable than individual therapy. This conviction has arisen from seeing, time after time, how much ego-strength there is in each of the group members, and how they lend very effective support to one another during difficult times."

Continuing his explanation of why he felt less comfortable in group than in individual treatment, he said, "I am especially anxious in the presence of 'social' conversation. . . . One time the members unani-



mously complained of feeling that they had to work all the time they were at the sessions. I considered their complaint to be well-founded on a real limitation of mine.

"Another thing—I felt threatened at the prospect of closeness between two members of the group. . . . They never seemed to become affectionate toward each other and they seemed very anxious about feeling and expressing affection. But I felt on more than one occasion that the prospect of their doing so was definitely unpleasant to me. It was as though my own security demanded that I be closer to each of the patients than they were to one another. This was something I became aware of only in the latter months of working with my group; heretofore they had been so distant from one another that the problem did not present itself. During one meeting about six months after the group started I became aware of anxiety at a time when the patients were having a lively discussion (about five of them were present), and I had been silent for perhaps fifteen minutes. I experienced the sensation of being farther and farther out of the group, being totally unnecessary and unnoticed. It happened that the anxiety was mild enough to allow me to see what was going on in myself, and I did not feel anxious in any of the later sessions when that situation arose.

"Between meetings I kept having fantasies that a certain psychotic patient would go berserk and beat up the other patients and myself. I had felt this about him in individual sessions too, but in the group I had not been aware of this fear. Even during the meeting during which he said to me, 'To hell with you, Agnes,' and things became very tense, I did not feel afraid of his assaulting me but rather was conscious of the need to control my anger toward him because of the need to handle this situation comfortably since the other patients were looking curiously to see how I took it. The recognition of the unconscious factor underlying my anger allayed my anxiety and when he resumed individual therapy with me after spending six months at a hospital, I felt much more comfortable with him than I had previously, was no longer afraid of his acting out—which he was still doing outside his analytic hours."

Dr. L. had the most detached manner in the group of any of the doctors and was the most reticent person. He had low tolerance for hostility directed toward himself and occasionally got angry with patients who displayed it. He did not challenge their defenses readily --"the patients are doing the best they can." He never seemed to feel obligated to protect a patient, and the general atmosphere of his group was "sink or swim." He seemed to show little awareness of the patients'

sensitivities. For example, he brought up subjects they had talked about in private interviews, without first asking their permission, if he thought it would be helpful for them to discuss such matters in the group. In his attempt to develop group relationships, he was rather directive in asking for comments but then refused to enter into discussion with any one patient. Instead, he asked for contributions from the others on the topic or urged the patients to relate to each other. The meetings of his group were characterized by the greatest patient-to-patient hostility—shown by sarcasm, belittling, and so on—but there were only one or two fleeting outbursts of hostility toward him.

Dr. N., one of the older and more experienced doctors, was academically minded and interested in theoretical concepts. At first, when a situation was unclear to him and the members of the group seemed to show no need for protection, he became anxious and dealt with this by cross-questioning a patient or pointing out logical contradictions. This tended to put the group on the defensive. He tended not to recognize hostility in himself and others and was unaware of the aggressiveness of his questioning. He showed some impatience with patients who were not intellectually quick. Like Dr. X, at times he seemed to become defensive when therapy was attacked even by implication or when patients complained of not making progress. On the other hand, perhaps as a reaction to these qualities, he sometimes tried too quickly to reassure patients when they expressed discouragement. He was rather reserved and detached when the patients were calm, but showed considerable warmth and protectiveness when a patient became obviously anxious or otherwise upset. He tended to individualize treatment but also kept group relationships in mind, the more so as he became experienced in group therapy. He showed the greatest willingness to permit tension to rise in his group. This was usually accompanied by more or less successful attempts at understanding and resolution.

Dr. P was an introverted, intellectually acute, detached person, who said that he had missed gang experiences in his boyhood and adolescence and therefore felt anxious in a large group. He worked much more comfortably in a group of two than in a group of seven. He tended to disrupt the development of group relationships. His anxiety led him to offer interpretations which, although sound, were at times cryptic and above the heads of the patients. He perhaps overvalued the schizoid patients as interpreters of the psychodynamics of the others and was too much inclined to keep them in this role—a tendency which seemed to be a reflection of his own personality and activity.

Dr. R had a very protective, fatherly attitude toward his patients and feared what they might do to one another. He seemed to feel that he was responsible for everything that happened, so that the more patients in the group, the greater strain on him. This may have been related to his tendency to focus on one patient at a time and to some extent to disregard the rest. He felt under much pressure to do a good job, and, as he said, regarded the observer at first as a super-ego, especially since he knew the observer was being analyzed by his own analyst. He fantasied that the observer reported to his analyst what he did poorly. He was physically powerful and was afraid of his own hot temper, which he consciously kept under rigid control. He was afraid of outbreaks by two mildly paranoid, overtly hostile patients to whom he was repressive in a kindly, protective way—deliberately sitting next to them at times. This attitude sometimes inhibited reactions in the rest of the group.

Dr. X, who was older and more experienced than most of the psychiatrists on our clinical staff, had a strong feeling of protectiveness toward his patients. He stated that the group contributed to his satisfaction in feeling that he was managing things behind the scenes, as he did in social events, when he was the host. He became defensive when patients attacked his therapy but not when they attacked him. There was an atmosphere of greater comfort and sociability in his group than in any of the others. Following his suggestion, his patients used first names from the start, and there was considerable banter in which he participated. His guidance was very firm. He selected topics for discussion at times and typically, if he felt a subject was too much for a patient to handle, would seize on some aspect of it in order to divert attention to another patient, using this aspect as a link. He was primarily interested in the problems of individual patients rather than their interplay in the group.

Dr. Z, a very reserved person, originally emphasized his desire to maintain "an aura of professionalism and seriousness." He seemed chiefly concerned with remaining uninvolved and keeping a psychological distance from each patient, but since he apparently felt that what he said was very significant to the patients, he was also concerned about what to say. He thought patients had a "right" to privacy in certain matters, particularly marital difficulties and therefore did not encourage this topic when it was brought up in the group. At first he was very constrained in the group, sitting with his head down and speaking rarely and in a quiet detached way, but later he became freer and more active. His group had more of a classroom atmosphere

than any of the others. There was very little overt tension. At the end of each meeting the doctor would sum up the points that had been learned.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

In our project it was apparent that the practice of analytically oriented group treatment needed the training and knowledge required in individual therapy and, in addition, an awareness of problems special to group therapy. Lack of this awareness could produce anxiety in the doctor and prevent him from taking therapeutic advantage of the group situation, with the result that he merely practiced individual therapy in a group setting. Furthermore, his therapy might be affected by his personal response to the group setting. Whether he felt more or less secure in group than in individual therapy depended in part on his attitude toward criticism, previous experience with family and social groups, reticence, and exhibitionism. The doctor's attitudes toward different aspects of leadership, power, and hostility in particular might have deleterious effects on both patients and himself if his reactions were unconscious or uncontrolled. Opportunity to discuss observations and problems was therefore of prime importance to the security of our clinical staff and made a considerable contribution to technical improvement and success.





**PART II**

***Group Therapy with  
Hospitalized Schizophrenic Patients***



## CHAPTER XVI

### *General Description of the Research with Schizophrenic Patients*

---

THE research on group therapy with chronic schizophrenics at the Perry Point Hospital involved four fundamental and little understood areas of psychiatry: (1) the dynamics of groups, (2) the nature of schizophrenia, (3) the nature and techniques of psychotherapy with schizophrenics, (4) and the relation of hospitalization to psychological treatment. To study any one of these is in itself a full-time pursuit, yet each is indissolubly related to the other. Since to do justice to them all was a task beyond the modest limits of our project, we found ourselves shifting the emphasis from area to area when one or another seemed to have increased importance as we worked.

Our main problem, however, was to learn *how* to treat a group, and we always returned to this as our goal. Unhappily, the *how* repeatedly led us to the question of whether it was possible to treat schizophrenics in groups at all. This, in turn, led us to inquire still further into what kind of people our patients were and how they were affected by the varied and numerous group situations. We also had to remember that only one hour of a patient's day was spent in the group. During the remaining time he was subjected to a kind of living that might undo or enhance the work of the hour. In the end we realized that we could not set any clearly defined limits to the study or work out any detailed protocols looking to a narrow and definite aim. Anything that appeared to affect the course of treatment became legitimate material for study. As in the study of clinic patients, we were able to make use of only a small part of our data. We therefore selected for intensive study those problems which seemed most important for therapy.



First, of course, we were faced with the problem of *how* to conduct the study. Techniques derived from past experience and the literature were tried and soon discarded, and so we had to consider what constituted sound methodology in this kind of research and then develop techniques to achieve our aims. At each turn our problems grew in complexity and diversity. Trying to answer any single question led to many more questions. Our primary task became one of indicating the areas in which the basic problems lay, delineating the broad patterns of their many interrelationships, and selecting a few for detailed study. To draw conclusions seemed too ambitious a goal, but we hoped to formulate hypotheses reasonably well grounded in our experience. Our first aim was to devise research methods:

1. To study the dynamics of therapeutic groups of schizophrenics and effective techniques of leading the groups.
2. To compare the progress of a ward of schizophrenic patients which received group therapy with a ward which was similarly administered but received no group therapy.

In studying therapy we recognized that the chief emphasis would need to be on the development and the working through of relationships formed in the group between patient and doctor, patient and patient, and patient and group. "Working through" to us meant developing an understanding of the patient's behavior, with the aid and support of the doctor and other group members, so that the patient could learn by participating in a group situation how to overcome the difficulties that blocked his relationships with people. We hoped to achieve our aims through communication of conflicts in ideas and feelings and through analysis of individual and group expressions of these conflicts.

Organization of such research involved the close cooperation of a relatively large number of people. In the first year of the experiment the groups were led by hospital residents in psychiatry whose actual experience with schizophrenics had been limited to single interviews with patients on the intake and chronic services. It was therefore necessary to incorporate a teaching program. We found that group therapy provided an excellent medium for teaching. The residents observed one another's groups and compared and discussed their own

and one another's treatment situations, usually with a senior member present. They observed a wide variety of types of schizophrenic speech and behavior under similar conditions. The discussions between the doctor and the observer after each meeting proved to be invaluable experiences. An atmosphere of enthusiastic participation developed.

On the debit side, we could not expect as much therapeutic progress as with more experienced doctors. In the meetings the doctors were often unclear as to their goals, their own roles, and the meaning of the patients' behavior. They were often anxious and insecure and changed their techniques as they learned. There was a tacit but clearly apparent competition to see who would get the most impressive results most quickly. They insisted on setting their therapeutic goals unrealistically high. This situation led us eventually to the idea that the first year of the project was primarily a learning experience for both junior and senior psychiatrists and was not a test of the ultimate value of group therapy. Actually, the inexperience of our doctors proved less of a handicap than we had thought it might. Very few psychiatrists have had experience in the therapy of chronic schizophrenia, and only a handful have attempted the type of treatment with which we were concerned. Our observations show in part the difficulties of the inexperienced in treating schizophrenia and what we learned from them.

In the middle of the first year a large group composed of all the patients on the experimental ward was formed by Dr. Abrahams (see Chapter XXIII). The weekly meetings of this group were intended to facilitate the therapy of the smaller groups, which were led by less experienced psychiatrists.

At the end of the first year all but two of the doctors in charge of groups left the hospital to continue training elsewhere. We took advantage of the year's experience to reorganize the groups along lines which were to prove more effective. A staff doctor who had observed the various groups intensively during the first year now gave full time to research. He had a particular interest in this phase of the work and had had experience in treating schizophrenia. Two additional staff doctors who had been administrators on the experimental ward also volunteered to lead groups. Both had treated schizophrenic patients individually.

During our first year we had avoided using ward administrators as therapists, since we thought that their meetings would be taken up with complaints. In the second year we had to forego this assumption, since no other doctors were available. In an attempt to keep the administrative and therapeutic functions distinct one administrator scheduled a special weekly meeting for the experimental ward as a whole which was called a gripe session. Similar meetings were scheduled for the control ward. No appreciable difference was noted in the character of the therapeutic meetings held by ward administrators.

As in the clinic, the research depended on the written records of observers. During the first year six residents volunteered to act as observers. A psychologist integrated the observations by working out methods of recording and analyzing them and collecting comparable data on experimental and control wards in order to help evaluate changes in patients. A staff psychiatrist collaborated on this with the psychologist.

In the second year, as no psychiatric residents were available to act as observers, a clinical psychologist was added to the staff. Two groups were selected for intensive observation by the psychologists, and other groups were observed by them at irregular intervals as often as possible. Another worker with some training in psychology recorded the observations of Dr. Abrahams' large meetings and did the statistical calculations.

At the start group observation posed a great many problems, owing to the extraordinary complexity, diversity, and ambiguity of the subject matter—namely, the language, behavior, and relationships of schizophrenics—and to the relatively undeveloped state of basic concepts. These factors made conceptualization of the basic problems an exceptionally difficult matter. From observation of a large number of meetings of many groups, we derived impressions which we used as backgrounds for our early formulations. As with therapy, training in observation proved to be a long-term procedure.

The research naturally involved administration at all levels. The patient population had to be maintained and special administrative measures had to be applied to it. Nurses and aides assumed responsi-

bility for reporting events according to a form from which statistical data were culled.

On the whole, there was some ambivalence toward the research on the part of both the medical and the non-medical staff. In the first months, especially, it represented for the latter changes in ways of thinking and behaving toward the patients. Soon, however, the hospital personnel began to take pride in the research, identifying themselves with it and deriving a feeling of importance and adventure from it. Doctors discussed the research with nurses and attendants, and a fine spirit of cooperation and interest developed. However, this fluctuated somewhat during the second year, when no spectacular "cures" took place. The research also became routine, but doctors continued to be less inclined to give shock or hydrotherapy and were more apt to talk with their disturbed patients.

Cases of chronic schizophrenia which had developed during and after World War II constituted the major psychiatric problem of the Veterans Administration. At the time our project was initiated the average length of hospitalization was over two years, and many patients had experienced episodes prior to the current admission. All but nine of our patients had had some form of shock treatment, predominantly electric shock (several series in many cases). Most had spent some time in individual psychotherapy at military or veterans' installations rather early in their illness. None had improved.

As beds became available in the experimental and control wards, patients were transferred from the admission or active treatment wards. The patients were housed in a large building, those who were receiving group therapy being housed in one wing and the control patients in the other. Both wards had the same administrator and a common over-all policy, but each had its own nurses and aides.

Although the experimental and control wards were well-matched for age, length of hospitalization, and diagnosis (Tables 15-17), we recognized from the beginning that it would be impossible to maintain a control ward which was identical with the experimental ward in every respect except for the group therapy. Our only recourse was to watch for factors that might introduce a bias in the administrative



or research staff. The group meetings conflicted with the daily routines of the two wards, and changes in the schedule of activities sometimes upset the patients and personnel. The patients in the experimental ward had to spend more time on the ward, since they were not given occupational therapy or grounds privileges while waiting for their meetings to begin. Some of the personnel, particularly the nurses, felt that the control patients were being neglected because they did not receive group therapy and therefore tended to give these patients more attention in other ways. One of the ward administrators reported that he had a tendency to select control patients for individual treatment, since they received less attention than experimental patients.

At first great pains were taken to maintain a strict separation of the wards to prevent a possible carry-over of therapeutic effect if patients from both wards were allowed to mingle freely, but later patients mingled outside the building in recreation and work details and in a lounge. When control patients learned of the group therapy from experimental patients or ward personnel, some expressed resentment or disappointment at not receiving it. One control patient indicated that he followed the reports of activities in group meetings with interest. No evidence was found, however, which would indicate a carry-over of therapeutic effect.

During the early months of the first year the experiment was complicated by the presence of acute and chronic alcoholics on the two wards, and their derisive, superior attitude and behavior were very disturbing until they were removed. At mid-year sweeping changes were made in the organization of the hospital. The doctors were disturbed by changes in duties and procedure, and the patients, apparently sensitive to their doctors' attitudes, became more active. Both the control and the experimental ward were therefore excluded from the reorganization. The patients nevertheless remained unusually active for some time, and inevitable changes in personnel tended to increase their excitement. During the winter of the second year a series of thefts occurred, and the subsequent investigations disturbed patients and personnel. Other events which had a direct bearing on specific aspects of the behavior of patients are discussed in later chapters.

Except for group therapy, the patients in the two wards received

TABLE 15. Age of Patients at the Time the Experiment Was Begun

<i>Group</i>	<i>Average age (M)*</i>	<i>Variability (S. D.)†</i>	<i>Range</i>
Experimental	28.17 years	5 years	20 to 41 years
Control	29.65 years	5 years	19 to 45 years

\*M=mean.

†S. D.=standard deviation.

TABLE 16. Length of Current Hospitalization at the Time the Experiment Was Begun

<i>Group</i>	<i>Average length of hospitalization (M)*</i>	<i>Variability (S. D.)†</i>	<i>Range</i>
Experimental	2.12 years	1.3 years	Less than 6 months to 5 years
Control	1.86 years	1.24 years	Less than 6 months to 5 years

\*M=mean.

†S. D.=standard deviation.

TABLE 17. Diagnosis at the Time the Experiment Was Begun

<i>Diagnosis</i>	<i>Experimental ward</i>	<i>Control ward</i>	<i>Total</i>
Paranoid	25	28	53
Catatonic	18	14	32
Hebephrenic	29	25	54
Simple	2	3	5
Mixed	12	8	20
Unclassified	2	8	10
<b>TOTAL</b>	<b>88</b>	<b>86</b>	<b>174</b>

TABLE 18. Groups Observed at the Veterans Administration Hospital at Perry Point: Summary of Attendance, Duration of Treatment, and Basis of Composition

Type of group	Doctor	Group no.	Date begun	No. of sessions	No. of patients	Average attendance	Patient hrs. of therapy	Basis for composition
<b>A</b>								
<i>Inexperienced doctors and inexperienced patients</i>	Dr. J	I	6-17-47	171	14	10	1,710	Mixed diagnosis
	Dr. O	II	7-21-47	152	14	12.5	1,900	Paranoid
	Dr. A	III	7-28-47	165	11	11	1,815	Catatonic
	Dr. M	IV	8-11-47	124	15	13	1,612	Hebephrenic
	Dr. Q	V-a*	10-13-47	45	24-16	16	720	Mixed diagnosis
	Dr. U	VI-a*	10-27-47	48	7-15	7	836	Mixed diagnosis
<b>B</b>								
<i>Inexperienced doctors and experienced patients</i>	Dr. W	VI-b	4-5-48	105	13	9	945	Mixed diagnosis
	Dr. G	VIII	9-13-48	65	13	9	585	High education
	Dr. V	X	12-27-48	49	10	9	441	Passive-dependent
	Dr. G	XI	12-27-48	53	11	8	424	Flat affect, freely verbal, deferential, no show of hostility, discussion of sex avoided
	Dr. F	XII†	4-3-48	24	31			Concomitantly receiving insulin shock

C <i>Experienced doctors and experienced patients</i>	Dr. B	v-b	3-22-48	198	13	9	1,782	Mixed diagnosis
	Dr. Y	vii-a†	10-28-48	99	9			Hospitalized less than 15 months, had received no shock therapy
	Dr. B	vii-b†	6-7-49					Same as vii-a
	Dr. M	ix	9-27-48	83	14	13	1,079	Dominant and submissive
						TOTAL	13,349	
						TOTAL NO. OF PATIENTS ON EXPERIMENTAL WARD	118	
						AVERAGE HOURS OF GROUP THERAPY PER PATIENT	113.13	

\*Eight patients were moved from v-a to vi-a to make the groups more nearly equal in size.

†The criteria by which Groups vii-a, vii-b, and ix were formed differed from those used in setting up the statistical experiment. Therefore none of these groups is included in the statistics on the research, and the number of therapy hours was not computed for them, although they are described later.



the same treatments.\* Hospital services were afforded equally. The two doctors who administered the building were available to patients on both wards for individual interviews as their time permitted, the occasion demanded, or the patients requested. Other treatments (sedation, hydrotherapy, and electric shock) were given as the need for them arose. When patients became too difficult to manage, they were removed to the acute service. Privileges were granted in accordance with the condition of each patient as determined by the ward administrator. All orders for patients were given by the ward administrators and not discussed with the therapists. An objective indication of changes and differences on the two wards was obtained from:

1. Privileges granted the patients.
2. Special measures taken to control patients' behavior.
3. Forms of behavior which presented problems in ward management.

Our research methods were oriented toward obtaining three types of data which would serve:

1. To evaluate group phenomena.
2. As indications of changes in patients undergoing therapy.
3. To compare experimental and control wards.

As in our research with the Mental Hygiene Clinic patients, group phenomena were studied from the running accounts of meetings, the analysis of situations that developed in the group meetings, and clinical records on all experimental ward patients. The latter gave information about the patient in his extra-group life and were recorded in the ward book kept by the nurses. They included reports on patients who got electric shock or hydrotherapy, and on those who fought, were injured, received grounds privileges, went AWOL, and so on. The information was descriptive and was transcribed on the research record of each patient. These data often explained in part what caused a patient to behave in a certain way in the group and, conversely, told us how he was affected in his extra-group life as a result of what occurred in the group.

Our original plans included a study of changes in patients receiving

\*Originally it was planned to have each doctor give as many hours of psychotherapy to individual patients as he did to groups, but there were not enough doctors to do this.

group therapy based on data from an evaluation of a random sample (25 per cent) to be given Rorschach tests and the specially devised interpersonal-relations interviews (see Appendix E) before and after treatment. These initial tests and interviews were given but were not repeated, principally because the task was too large for the small research staff.\*

The patients in the experimental ward were originally divided into six groups, meeting for an hour five times a week. The residents insisted that the groups be composed according to diagnosis. This was seriously questioned by the senior staff, but after discussion it was permitted. In the second year composition was determined by certain characteristics among patients, described in detail later.

By the end of the first half of the first year all experimental ward patients were in groups meeting three or four times a week. During the second year only 75 per cent of these patients could be continued in group therapy because we did not have enough doctors. In the second half of the second year two special groups were studied: one composed of patients whose illness was of comparatively recent onset and who had received no shock treatment and the other composed of patients on the acute service who were receiving insulin shock. Our object was to discover whether group therapy would be more effective with these patients, and, if so, to apply what we had learned to the treatment of chronic illness.

Table 18 presents the summary of the attendance, duration of treatment, and basis of composition of three types of groups observed from June 1947 to April 1949.

\*For a year nurses made ratings monthly on each patient in reference to: appearance, cooperation, speech relevance, mood, hallucinations, delusions, orientation, judgment and insight, and sleep. These were found to be unreliable and were discontinued.

## CHAPTER XVII

### *Statistical Summaries\**

---

#### THE CATEGORIES

IN comparing the progress of the patients in the experimental ward at Perry Point Hospital with that of the control patients we searched for categories of statistical data having a demonstrable relation to therapy. Those finally chosen included general observations on which statistics could be compiled daily for both wards. The categories were tested and then more rigidly defined. On the positive side we scored certain "freedoms" (see Table 19): discharges, trial visits, extensions of trial visits, leaves of absence, gate passes, and grounds privileges. On the negative side we scored revocation of grounds privileges (Table 19) and certain measures designed to control patients' behavior (Table 20): sedation, packs and tubs, electric shock treatments, and transfer to the acute service. The necessity of keeping accurate daily records was impressed on the nurses, and the aides were instructed in the importance of reporting all incidents that occurred on the wards.

#### *"Freedoms"*

*Discharges.* Patients were not recommended for discharge unless they were considered to have received "maximum hospital benefit," were free of psychosis, had given evidence of being able to work, and required no follow-up care. If doubt existed in regard to any of these conditions, the patient was sent out on a trial visit lasting from thirty to ninety days. Very few discharges were made without a preliminary trial visit. Each discharge was *scored once*.

*Trial visits.* To be recommended for a trial visit a patient had to be

\*Major contributors: David Rosenthal and Mary Touhy.

TABLE 19. "Freedoms" Granted Patients from November 1947 through April 1949

<i>Freedoms</i>	<i>Experimental ward</i>			<i>Control ward</i>			<i>Critical ratio<sup>o</sup></i>
Discharges	11			6			Not computed
Trial visits	39			35			Not computed
Extensions of trial visits	46			40			Not computed
Leaves of absence	50			59			Not computed
Gate passes	542			516			Not computed
	<hr/>			<hr/>			
	<i>Mean†</i>	<i>Total</i>	<i>S. D.**</i>	<i>Mean</i>	<i>Total</i>	<i>S. D.**</i>	
Grounds privileges granted	9.3	168	4.52	6.7	120	2.23	2.11 E > C
Grounds privileges revoked	5.3	96	3.25	4.0	72	1.63	1.48 E > C

2.11 E &gt; C

1.48 E &gt; C

C. R. required for significance at 5 per cent level=2.11.

C. R. required for significance at 1 per cent level=2.89.

<sup>o</sup>The term "critical ratio" refers to a statistical test which tells how frequently an obtained difference between two group scores may be expected to occur by chance alone. Significance at the 5 per cent level means that such a difference may be expected to occur by chance one time in twenty at most. Differences at this level are generally accepted as valid. The expression "E > C" means that the difference is in favor of the experimental ward; "C > E," in favor of the control ward. When the difference is so small as to be obviously not significant, the critical ratio is not calculated. For a discussion of the critical ratio and its calculation, see Quinn McNemar, *Psychological Statistics*, New York, Wiley and Sons, 1949.

†In Tables 19, 20, and 23: Mean=the average per month. N=18, the number of months.

\*\*S. D.=standard deviation of the monthly totals.

free of hallucinations and delusions and capable of caring for himself, of usefully occupying his time, and of getting along with people without undue friction. Sometimes, however, trial visits were allowed for the following reasons: the patient had improved and was so eager to go home that further hospitalization was considered detrimental; the patient did not appear to be benefiting from hospitalization and it was not considered unsafe for him to leave; the patient had a poor prognosis but the family was prepared to accept him; the family insisted on taking the patient out against advice. Each trial visit and each extension was scored once.

*Leaves of absence.* Leaves of absence, lasting from four to twenty-



nine days, were granted to non-suicidal and non-homicidal patients, if their relatives accepted responsibility for their care. Relatives were asked to see that patients of the experimental ward returned promptly so as not to interfere with treatment. Each leave of absence was *scored once*. Extensions were not scored unless they became trial visits. AWOL patients transferred to LOA status were scored under LOA.

*Gate passes.* Gate passes, lasting from several hours to three days, were granted to patients who could be trusted to leave the grounds for a short time without injury to themselves or others and who would return on time. Such patients were frequently psychotic and still very ill but were considered unlikely to get into trouble. Each gate pass was *scored once*.

*Grounds privileges.* Grounds privileges were granted to non-suicidal patients who were not aggressively antisocial, who were sufficiently well oriented to know the building in which they resided and able to return there for meals and treatments and at bedtime, and who did not habitually go AWOL. Each permit for grounds privileges was *scored once*, and likewise each revocation of the permit was *scored once*.

*Analysis of Table 19.* Of the 11 discharged experimental ward patients, 2 were ready for discharge before they were placed in groups, and 1 was later temporarily admitted to the ward while awaiting completion of arrangements for discharge. These 3 had no group therapy. Of the 6 control patients discharged, 3 were ready for discharge at the beginning of the study and 1 was later admitted to await discharge. There were left then 8 experimental ward patients as compared with 2 control patients who were discharged during the period covered by the experiment. Of the 8, 1 had only one hour of therapy and another had had only five hours and therefore could not be considered in the results.

It is difficult to determine the precise role of therapy in the remaining 6 discharges. The patients had not worked through their problems in the traditional sense, involving catharsis and insight. Nor is there specific evidence that their improvement was due to the supportive or ego-integrative aspects of treatment. It is possible that the larger number of discharges on the experimental ward represented a statisti-

cal artifact involving unknown and inadequately controlled variables. However, observation of these patients in their groups suggests a relation between therapy and discharges.

Trial visits, leaves of absence, gate passes, and grounds privileges were assumed to represent degrees of improvement in patients, but administrative expediency and family circumstances played a large role in the issuance of some of these privileges. Ward administrators were especially loath to grant leaves of absence to experimental ward patients and usually took pains to point out to relatives that special treatments were being given which should not be interrupted. As families were apt to agree that such patients should remain in the hospital, leave of absence figures are weighted in favor of the control ward.

Aside from leaves of absence, experimental ward patients tended to receive more freedoms than the control patients, although the difference is significant only for grounds privileges granted. Of those granted, experimental ward patients had theirs revoked 57 per cent of the time while control patients had theirs revoked 60 per cent of the time, indicating no significant difference in this respect.

In general, then, there seems to have been a therapeutic effect which enabled more experimental ward than control patients to receive and retain their freedoms.

### *Special Measures to Control Patients' Behavior*

*Chemical sedation.* Ward administrators avoided giving chemical sedation whenever possible. It was ordered mainly when facilities for hydrotherapy were not available or when other measures had failed. Daytime doses were given to disturbed patients with diffuse anxiety and to those needing it when attending clinics. Each dose given was *scored once*, and the number of patients receiving sedations was tabulated.

*Packs and tubs.* Hydrotherapy was administered on the usual indications. Each pack or tub treatment was *scored once*, and the number of patients receiving either was tabulated.

*Electric shock.* Electric shock was given when a patient became suicidal, extremely depressed, or too active to be handled on the ward;

when he refused to eat; or when the administrator thought it would relieve undesirable behavior such as prolonged mannerisms. Exceptionally, it was given at the insistence of a patient's family. Each electric shock treatment was *scored once*, and the number of patients who received it was tabulated. One administrator reported that he might have had a slight tendency to prescribe shock for control patients more readily than for experimental ward patients, since the former did not have the benefit of group therapy. He also thought that giving shock to an experimental patient might disturb the group. This, however, was a relatively minor factor in accounting for the difference between the two wards.

*The acute service.* As a rule patients who became assaultive or suicidal were treated by removal to the acute service, whereas disturbed patients were treated with sedation. Depressed, withdrawn, or autistic patients were treated with electric shock. Each day spent by a patient temporarily assigned as a "guest" to the acute service was *scored once*, and the number of such patients was tabulated. In extreme cases patients were transferred to the acute service.

*Analysis of Tables 20-22 and Charts 5 and 6.* It appears from Table 20 that two-thirds of all chemical sedation was administered to control patients. About 87 per cent of all sedation was given at night, and control patients had 70 per cent of all night sedation. During the day experimental ward patients had more than twice as much sedation as control patients, but the total amount of day sedation was relatively small. This suggests that some experimental patients may have become upset by group therapy meetings, occasionally needing sedation to see them through the day. At night, however, these patients were calmer whereas the control patients generally tended to be more disturbed.

There were no statistically significant differences in the number of packs and tubs given or in the number of patients receiving hydrotherapy.

More electric shock treatments were used on the control ward than on the experimental ward, and more control patients received them, except during a short period in 1948, when the over-all changes in hospital administration referred to in Chapter xvi were under way.

During the second year there was a marked diminution in the number of treatments given on both wards, but the decrease was less marked on the control ward. Observation of the group therapy meetings suggested that some of the experimental ward patients were helped to stave off intense depression and withdrawal by verbalizing and acting out feelings and ideas. It is also of interest that the experimental ward administrator ordered no electric shock treatments for patients in the group led by the most experienced doctor.

More experimental ward patients spent more time on the acute service than did control patients during the first year, but during the second year the decrease in the number of guest days was far larger for experimental ward patients than for control patients. The data would seem to indicate that initially the experimental ward patients expressed more hostile impulses as a result of group therapy. This may have been due to the way in which the groups were composed, the inexperience of the doctors, or even the type of group therapy practiced. At any rate, it seems clear that the aggressive behavior subsequently diminished.

Tables 21 and 22 and Charts 5 and 6 show very clearly that, except in the chemical sedation used during the day on the control ward, there was a marked drop in special treatments given during the second year. The marked peaks shown between November 1947 and May 1948 in Charts 5 and 6 follow closely upon and may be related to the changes that were made in the routine of all the patients when they were moved to the new building and to the later administrative changes that were very disturbing to the staff and consequently to the patients.

#### *Forms of Behavior Presenting Problems of Ward Management*

Records were kept of combative and destructive episodes, injuries to patients and personnel, urinary and bowel incontinence, and absence without leave.

*Destructive or combative episodes.* Patients were considered combative if they hurt or had to be restrained from hurting one another. They were *scored once* for each day of destructive or combative behavior; if blows were exchanged all participants in the altercation



TABLE 20. Special Measures Taken to Control Patients' Behavior from November 1947 through April 1949

SPECIAL MEASURES	EXPERIMENTAL WARD			CONTROL WARD			CRITICAL RATIO
	Total	Mean	S. D.	Total	Mean	S. D.	
Chemical sedation (day)	71	3.9	4.9	29	1.6	3.5	1.61 E > C
(night)	250	13.9	18.2	583	32.3	30.8	2.12 C > E
Electric shock treatments	426	23.7	17.8	688	38.2	19.4	2.30 C > E
Patients receiving electric shock	73	4.3	2.9	120	7.0	2.4	2.87 C > E
Packs and tubs	254	14.1	15.1	206	11.4	13.9	.54 E > C
Guest days on acute service	204	11.3	14.4	93	5.2	6.6	1.56 E > C
Patients transferred to acute service	2			1			

C. R. required for significance at 5 per cent level=2.11 when N=18.

C. R. required for significance at 1 per cent level=2.89 when N=18.

TABLE 21. Average Number of Treatments per Month

KIND OF TREATMENT	EXPERIMENTAL WARD		CONTROL WARD	
	1st year	2nd year	1st year	2nd year
Chemical sedation (day)	4.4	3.6	1.0	2.1
(night)	27.1	3.3	59.4	10.7
Packs and tubs	26.6	4.1	20.1	4.5
Electric shock	39.4	11.1	48.0	30.4
Guest days on acute service	22.5	2.4	7.4	3.4

TABLE 22. Average Number of Patients Treated per Month

KIND OF TREATMENT	EXPERIMENTAL WARD		CONTROL WARD	
	1st year	2nd year	1st year	2nd year
Chemical sedation (total)	4.0	2.2	3.7	1.4
Packs and tubs	6.9	2.3	6.7	2.6
Electric shock	6.9	2.5	8.9	5.8
Transfer to acute service	2.14	.4	1.14	.4

NUMBER OF PACKS AND TUBS GIVEN IN  
EXPERIMENTAL AND CONTROL WARDS

NOVEMBER, 1947 - APRIL, 1949

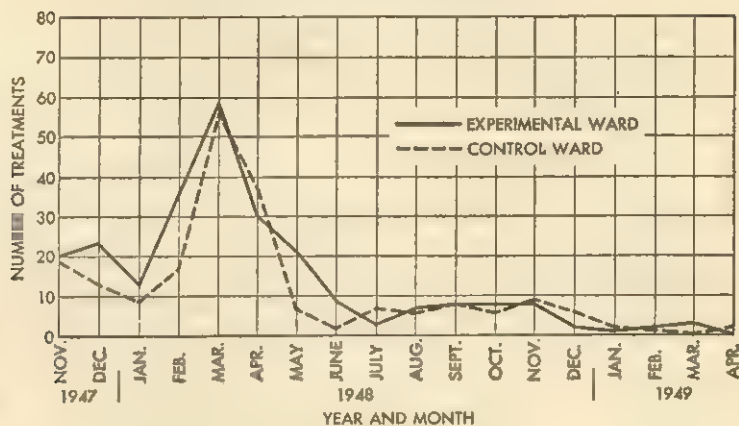


CHART 5

NUMBER OF ELECTRIC SHOCK TREATMENTS GIVEN IN  
EXPERIMENTAL AND CONTROL WARDS

NOVEMBER, 1947 - APRIL, 1949

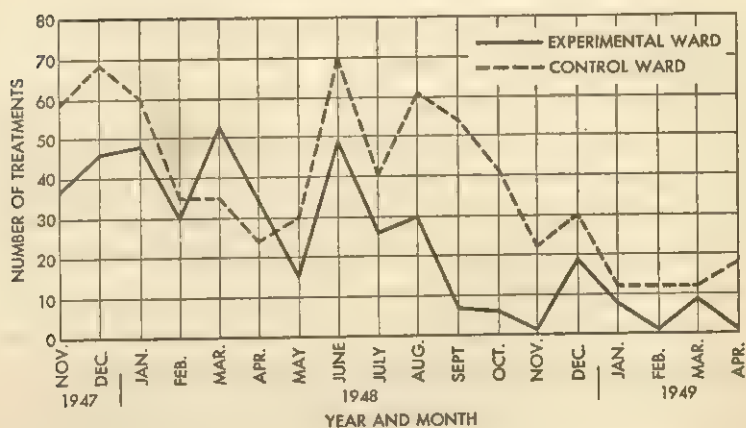


CHART 6

were scored. Each injury, whether sustained by patients or personnel, was scored *once*; at first there was a tendency for personnel not to report minor injuries, but with repeated explanations record-keeping became more accurate.

*Incontinence.* Patients were also scored *once* for each day of urinary

EPISODES OF INCONTINENCE  
DECEMBER, 1947 – APRIL, 1949

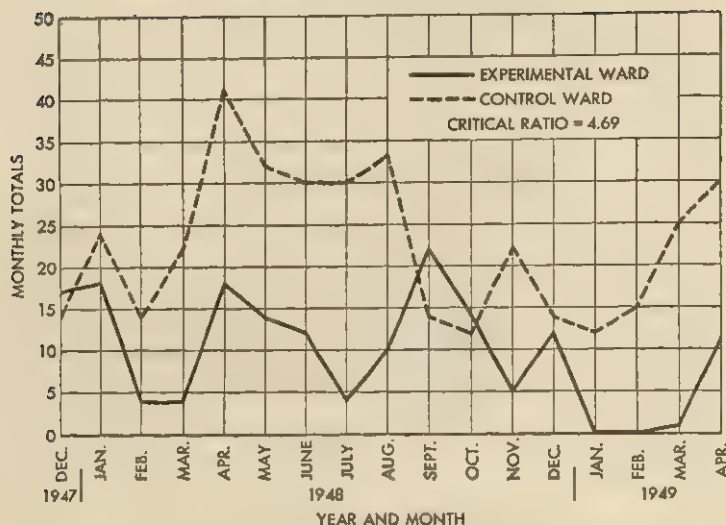


CHART 7

or bowel incontinence. (Habitual bed-wetters were awakened during the night to prevent such occurrences.)

*Absence without leave.* Patients who left the grounds without permission, overstayed leaves, or wandered around the hospital grounds without returning to the ward, were *scored once* for each such episode.

*Analysis of Tables 23 and 24 and Chart 7.* There were more destructive and combative episodes on the experimental ward than on the control ward during the first year but fewer during the second year. The decrease in such episodes was about 60 per cent per month on the experimental ward and about 45 per cent on the control ward. When the two are compared, however, the difference is not statistically significant. The number of patients injured decreased about 50 per cent per month on the experimental ward but increased about 20 per cent on the control ward. It therefore appears that patients receiving group therapy expressed their hostile impulses more freely at first but later tended to be less aggressive than patients who did not receive such therapy.

There were fewer episodes of incontinence on the experimental

TABLE 23. Forms of Behavior Which Presented Problems of Ward Management

BEHAVIOR PROBLEMS	EXPERIMENTAL WARD			CONTROL WARD			CRITICAL RATIO
	Total	Mean	S. D.	Total	Mean	S. D.	
Destructive and combative episodes (total)	345	20.3	12.2	319	18.2	7.6	.58 E > C
Patients injured	113	6.3		112	6.2		
Episodes of incontinence (total)	165	9.7	6.7	384	22.6	8.7	4.69 C > E
Absences without leave	80	4.4	2.1	47	2.6	1.5	2.86 E > C

C. R. required for significance at 5 per cent level=2.11.

C. R. required for significance at 1 per cent level=2.89.

TABLE 24. Average Number of Behavior Problems Occurring Monthly

BEHAVIOR PROBLEMS	EXPERIMENTAL WARD		CONTROL WARD	
	1st year	2nd year	1st year	2nd year
Destructive and combative episodes	31.3	12.6	25.6	14.0
Patients injured	8.8	4.3	5.6	6.7
Episodes of incontinence	12.4	7.8	25.3	20.7
Absences without leave	4.5	4.4	1.5	3.5

ward than on the control ward during almost every month of the study. Although the curves for the two wards present parallel trends (Chart 7), the difference is greater in this category than in any other (see also Tables 23 and 24).

Experimental ward patients went AWOL more frequently and more consistently than control patients. Although there was no appreciable change in frequency on the experimental ward during the second year, AWOL's on the control ward more than doubled. On the assumption that group therapy was responsible for the greater number of



AWOL's on the experimental ward, it is possible that the "gripe" sessions held during the second year on both wards were responsible for the increase of AWOL's among control patients, since these sessions came to have many of the features of group therapy meetings.

### *Other Aspects of Patients' Behavior\**

Since we wished to compare the experimental ward patients with the control patients in respect to communication, co-operation, and interest in activities and surroundings, we decided to observe both types of patients in organized social groups and in the day rooms. During the first year observations were made at irregular intervals in all four day rooms (open experimental, open control, closed experimental, and closed control) for two five-minute periods each, morning and afternoon, on a given day. During the second year the four rooms were observed for one five-minute period, alternating morning and afternoon, on a given day. The observations were made by five experienced persons (four social workers and one psychologist), who worked in pairs. Those who observed in the second year were different from those who observed in the first year.

#### WARD OBSERVATION RECORD

Ward	O	E	Date.....	Time.....	to .....	Observer.....
	L	C				
Total No. ....						Climate .....
Motor Activity						Relating      Verbal      Non-verbal
Walking (directed) .....						Self .....
Pacing .....						Patient to Patient .....
Other .....						Cluster .....
Spontaneous Purposeful Activity						Staff .....
Reading .....						Observers (b) .....
Writing .....						(f) .....
Other .....						(m) .....
Description:						

Because of the number of patients who were simultaneously observed in each of the four day rooms, it was obviously not feasible for the observer to report in narrative style. A record form was there-

\*The method for this study was devised by Henry S. Maas and Edith Varon.

fore worked out in which various types of activity could be tallied (see opp. p.). In checking the forms at the end of the study, it was found that the agreement reached by each pair of observers ranged between 90 and 100 per cent.

The atmosphere of the day room was described under the category *climate* in two or three words—for example, “sleepy” or “hyperactive.” Under the other main categories—*motor activity*, *spontaneous purposeful activity*, and *relating*—tallying was done without regard for length of time spent in a given activity or its repetition by the same patient.

Under *motor activity* each patient who walked toward a definite goal and each patient who paced aimlessly about was *scored once* in its appropriate category. Sweeping the room, waxing the floor, washing the windows, and similar activities were scored under *other*. Mannerisms, changes in catatonic posturing, standing up, and sitting down were not scored.

Under *spontaneous purposeful activity* each patient who read, wrote, worked a puzzle or played solitaire was *scored once*. Listening to the radio was scored when there was a clear indication of participation, such as changing the station or whistling with the music.

Under *relating* each instance of verbal or non-verbal communication was *scored once*; in this category we included deliberate attempts to catch the attention of another or indicating a desire for a light, but casual glances were not scored. Card-playing by two patients was *scored once* as a *patient-to-patient* relation under either the verbal or non-verbal column, depending on whether the players spoke to each other. Three or more patients talking together or working silently on a jigsaw puzzle were *scored once* under *cluster*. Communications with the observers or hospital personnel were tallied under *staff*. Laughing was not scored unless it indicated a response to external stimulus.

Comparable quantitative data were obtained in percentages by dividing the total number of tallied activities on each Ward Observation Record by the number of patients in the day room during the five-minute observation period.\*

\*A possible source of error was introduced, when, in the second year, 9 patients were put on the experimental ward (then consisting of 82 patients). These had been hospitalized a shorter time and had not had shock therapy. They were counted because it was not practical to exclude them.

*Analysis of Table 25.* In all but one of the above manifestations of social behavior, experimental ward patients exceeded control patients. But the difference was statistically significant in only one category—non-verbal relating on the open wards in the first year. Still the consistent trend is greater than might have been expected to occur by chance and probably reflects the import of group therapy.

The differences between experimental ward and control patients became more significant in the second year in both open and closed wards with respect to verbal relating, while the differences in non-verbal relating and motor activity became less significant. This may represent reflection of the doctor's efforts to encourage patients to verbalize rather than act out their feelings.

*Analysis of Table 26.* The findings of the second year are broken down in Table 26 in greater detail. Under *motor activity*, it is noteworthy that experimental ward patients did more directed walking, while control patients did more aimless pacing or performed more routine "housekeeping" tasks. Under *spontaneous purposeful activity*, it is clear that experimental ward patients did more reading while control patients on the open wards worked puzzles by themselves, played solitaire, or listened to the radio more often. For the most part, too, experimental ward patients were more interested in communicating verbally with others. These data suggest that experimental patients showed greater interest in their social surroundings.\*

#### SUMMARY

More discharges were granted to experimental ward patients than to control patients but this difference was not found to be statistically significant. However, on the basis of observation we felt that to some extent it reflected the influence of group therapy. Experimental ward patients were also granted more grounds privileges than control patients and showed a slightly greater (but not statistically significant) tendency to retain them.

\*Since this trend was already manifest in the first year, it is possible that the imbalance of controls during the second, caused by the addition of 9 less chronic patients to the experimental ward, was not very great. Nevertheless the data should be interpreted with caution and accepted with reservation.

TABLE 25. Critical Ratios Between Experimental and Control Populations on Closed and Open Wards

CATEGORY	CLOSED WARDS		OPEN WARDS	
	1st year	2nd year	1st year	2nd year
Motor activity	1.60 E > C	.23 E > C	1.94 E > C	.64 E > C
Spontaneous purposeful activity	.06 E > C	1.03 E > C	.81 E > C	.59 E > C
Verbal relating	.94 E > C	1.95 E > C	.44 C > E	1.16 E > C
Non-verbal relating	.81 E > C	.54 E > C	2.39 E > C	1.17 E > C

1st year N=14, the number of observation periods. C. R. required for significance at the 5 per cent level=2.16; at the 1 per cent level=3.01.

2nd year N=25. C. R. required for significance at the 5 per cent level=2.06; at the 1 per cent level=2.79.

TABLE 26. Critical Ratios for Observations during the Second Year

Category	Closed wards	Open wards
Motor activity (total)	.23 E > C	.64 E > C
Directed walking	1.25 E > C	.90 E > C
Pacing	1.37 C > E	1.11 C > E
Other	.93 C > E	.06 C > E
Spontaneous purposeful activity (total)	1.03 E > C	.59 E > C
Reading	1.11 E > C	2.64 E > C
Other	.14 E > C	2.43 C > E
Verbal relating (total)	1.95 E > C	1.16 E > C
To self	.30 C > E	1.16 E > C
To staff	2.60 E > C	.63 E > C
To female observer	.74 E > C	1.82 E > C
To male observer	1.02 E > C	1.69 C > E
Non-verbal relating (total)	.54 E > C	1.17 E > C

N=25. C. R. required for significance at the 5 per cent level=2.06; at the 1 per cent level=2.79.



In general, the data on measures to control patients' behavior and behavior problems suggest that experimental ward patients tended "to do something" about their upsets whereas control patients expressed their upsets with increased depression, withdrawal, manneristic behavior, or diffuse anxiety. This is indicated by control patients needing more sedation and electric shock and having more episodes of incontinence, whereas experimental ward patients were more often removed to the acute service and more often went AWOL.

The data on ward observations seem to indicate that the group therapy had a generally stimulating effect on patients in regard to outwardly purposeful activities and verbal relationships with others.

Considering the chronic nature of the illness of the patients and the relatively few hours of treatment received by the majority, it was remarkable that we saw as much difference as we did in the two wards. The overt behavior may or may not, of course, be an indication of the nature of the changes taking place during therapy. The relation of the changes in the patients to therapeutic techniques is discussed in Chapter xx.

The parallel nature of the curves indicating changes in patients (Charts 5, 6, and 7) indicate that the controls were adequate. The flattening of the curves in the second year may indicate a trend toward stabilization in terms of the hospital setting.

## CHAPTER XVIII

### *Composing Groups of Schizophrenic Patients\**

---

IN composing therapeutic groups of chronic schizophrenics at the Perry Point Hospital we set out with no guiding principles. Theoretically, such groups might be composed according to any combination of the following factors, which seem to be the ones most significantly involved: number of patients; diagnosis and chronicity of illness; personal characteristics of the patients; personal characteristics of the doctor; sex of patients and doctor. But in order to estimate the effects of systematic variation in any one of these variables, the others would have to be constant. If we had tried to follow this procedure, we should of course have run into an exorbitantly high number of separate experiments, each of which would have consumed more time and personnel than we had at our disposal. Since this was apparent from the outset we decided instead to adopt a trial-and-error method, involving single instances of the above factors in various combinations, and to make an impressionistic evaluation of our observations on each. Hence, we are not able to offer any definitive formulations in regard to the many problems of group composition but can only describe in historical fashion what our experiences were in this regard.

#### OPTIMAL SIZE OF GROUPS

Initially, we composed four groups varying in size from 12 to 15 patients, one group of 7 patients, and one group of 24 patients. Somewhat later all the patients of the experimental ward met together once a week. This group of approximately 80 patients is described in detail in Chapter xxiii. The consensus among the doctors was that groups

\*Major contributor: David Rosenthal.

of 10 to 15 patients were optimal for therapy. In the smallest group the range of behavior patterns was narrow, and the tension aroused by the increased obligation on each patient to participate seemed to have a retarding effect. There were only a few resources upon which the doctor could draw when the group situation became difficult, as during a profound silence, and if one or more patients happened to be absent these resources were reduced still more. It may be, however, that our experience with this group is applicable only to the early stages of groups of chronic patients, since analogies were not observed in a mature group which had dwindled to 8 patients or even in the early stage of a group of 8 patients whose illness was comparatively recent.

The group of 24 patients never really became structured. Here the opportunities available to each patient for verbalizing or for developing a relationship with the doctor were notably diminished, and the doctor found it hard to keep all the patients in mind at the same time. After the group had been reduced to 15 these difficulties were remedied considerably. Of the patients removed, some who had maintained a consistent silence began to speak in the groups to which they were transferred and one such patient soon became a leader in his new group.

#### GROUPS COMPOSED ON THE BASIS OF DIAGNOSIS

Our first groups were composed on the basis of diagnosis. A number of residents wished to lead homogeneous groups, and so, even though on theoretical grounds this was not considered sound, they were allowed to compose groups on the basis of the three schizophrenic subtypes. But it was quickly apparent that these "pure" or homogeneous groups were not pure, that catatonics manifested paranoid and hebephrenic features, and that some paranoids appeared more catatonic than paranoid; in brief, that certain behavior patterns were common to some patients in all groups. This was our first clue that composition by diagnosis was not helpful. In addition, the "mixed" groups seemed to fare better in that the members showed a greater tendency to modify and extend their patterns of group behavior.

None of the "pure" groups fared well. The catatonic group was silent at first and then, after a brief period of activity, established a silence which was extremely trying to the doctor and which could not be broken. In the paranoid group one patient, who talked almost incessantly in a loud voice, monopolized the meetings and was largely instrumental in preventing therapeutic relationships from forming in the group. The hebephrenic group started with an intensely hostile barrage against the doctor and then subsided into a prolonged, hostile silence. In all three groups attempts at forming relationships were made, but these could not be developed beyond a very primitive stage, either because of the more monolithic behavioral patterns manifested in the group or because of the involvement of the personal characteristics and techniques of the doctors.

#### PERSONAL CHARACTERISTICS OF DOCTOR AND PATIENTS

We began to see more clearly that the composition of the group could not be considered apart from the type of doctor who led it. The doctor who led the catatonic group, for example, had an exceptionally even temperament and spoke slowly and methodically in a relatively unmodulated voice. Would a doctor of more sanguine temperament have fared better in dealing with patients who could not express their feelings? The doctor who led the paranoid group was relatively inactive, easy-going, and permissive. Would a more aggressive leadership have been more effective in resolving the monopolistic situation in this group? The doctor who led the hebephrenic group informed the research staff that the pattern of hostile silence which his group had developed was extremely painful to him. In his own personal analysis, while discussing this problem, he remembered that his own father had used silence to punish him, sometimes not speaking to him for a month at a time. Would the pattern of silence have developed in the hebephrenic group if this had not been such a sensitive issue with this doctor? Another doctor stated that he felt more comfortable when patients were openly hostile in the group. He encouraged and provoked hostile expression, but it became a definite group pattern that he could not resolve. How much of this hostile expression was



due to the composition of the group and how much to the doctor's own personality pattern?

Individual patients sometimes responded differently to individual doctors. In one group, for example, Patient A related freely to the doctor and presented many of his symptoms in the early meetings, while Patient B was a peripheral, relatively non-verbal member. Then another doctor took over the group. Shortly afterward Patient B became the most verbal, dominant, and therapeutically oriented member, while Patient A became almost totally silent. It was more than six months before the latter discussed his symptoms with the second doctor.

We also noted that certain patients presented special problems. One type had a flat affect, a superficially friendly, deferential approach to the doctor and well-integrated speech but low tolerance for the expression of hostility or for discussion of sexual or personal themes in group meetings. Such patients commonly played a neutralizing role in the group. They behaved in a superior fashion to the other patients, whom they often regarded as "crazy," and sought a dependent, favorite-son position in regard to the doctor on the basis of their assumed superiority. Two of these patients developed acute catatonic reactions when group circumstances threatened them. One, while in his catatonic phase, said that he could not tolerate the homosexuality going on around him. He had never discussed sexuality in the group before, and one would not have known from his behavior that the group had presented a sexual threat to him.

A monopolistic patient in the paranoid group also constituted an important problem. Some of our doctors took the view that his group should and would silence him, to the mutual benefit of all concerned. But after placing him in three different groups (including the large one), under the leadership of four different doctors, all of whom tried various techniques without success, we finally had to eliminate him because of his disruptive effect.

With the above considerations in mind, we reorganized our groups at the beginning of the second year in so far as possible on the basis of some compatibility of personal patterns in group and doctor. Unfortunately, the number of doctors available to our project had now

been reduced to five, and we could not form all the combinations that we should have wished to observe.

The group that had reached the stage of expressing intense hostility to a hostility-inviting doctor was kept intact, but the first doctor was replaced by one who encouraged more positive relations while at the same time having an unusual degree of tolerance for expressed hostility. This group subsequently became our most successful one.

A second group was composed of patients who were passive, timid, shy, dependent, childlike, and essentially mute. Many of these were selected from the catatonic group which had failed during the first year. The doctor of this new group was a woman who was warm, feminine, and maternal, and the patients subsequently manifested many hopeful changes. One who had been mute throughout the history of the catatonic group gradually began to verbalize; he eventually became the most vocal member, jealously guarding his focal position in regard to the doctor. Another, who had previously been in two different groups with three successive male doctors and had spoken but one sentence in the meetings he had attended during the first year, soon began to express himself verbally, becoming the first member to assume the focal position. A third patient, who had been considered out of contact in his previous group, suddenly asked the new doctor for grounds privileges because he wanted to sit in the ward lounge. When his request was granted, he spent most of his time in the lounge, just as he had said. Two patients expressed hostility to the doctor, both telling her to "go away" from them. Others began to masturbate openly in the group. One patient asked his mother if the doctor could have a baby. The hostility and erotic interest which these patients expressed in relation to the doctor were in marked contrast to the rigid, "frozen" aspects they had presented during the first year.

A third group was formed along lines of dominance and submission. The members were characteristically either domineering, aggressive, and voluble or overtly fearful, retiring, and essentially mute. The doctor for this group was the one who had led the hebephrenic group and who had had difficulty with the problem of silence. He conceived his role to be a passive and, as he said, an "impersonal" one. In this second-year group no problem of silence occurred, the dominant mem-

bers engaging in free discussion among themselves and with the doctor. One went into remission and is adjusting well outside the hospital; another began to discuss his homosexual preoccupations in more open, direct terms. The mute, passive patients appeared more comfortable in this group than they had in their previous groups. Two began to verbalize, one rather aggressively.

We tried to compose one group of patients of the deferential type, with flat affect and low tolerance for hostile expression or sexual discussion. Since we did not have enough of them, we added several others who approached these criteria but to a lesser degree. The doctor for this group was an unusually soft-spoken man who himself had difficulty in expressing hostility. The patient described above who had felt a sexual threat in his first-year group was placed in this one. He immediately became anxious again, monopolizing the group's and the doctor's attention in the process. As his anxiety increased without apparent resolution, he was soon removed from the group to prevent another catatonic reaction. His anxiety then subsided, and no catatonic attack occurred. Another patient who had avoided coming to the meetings of his first-year group, was induced to come to this one. Subsequently he began to exhibit himself around the hospital, and his grounds privileges had to be revoked. He gradually became more withdrawn, following the usual catatonic pattern. As yet we have found no way to treat such patients in groups; on the basis of our experience it would seem that group therapy with them is contraindicated.

The same doctor who led the last-mentioned group was also given a group of patients with various diagnostic and personality patterns, but all of whom had high-school education or better. Since the patients in this group manifested no unusual changes, we have no evidence for assuming that scholastic achievement is a useful criterion for composing groups.

#### SEX OF DOCTOR AND PATIENTS

What differences occurred when the doctor was not of the same sex as the patients? A female doctor treated the group of passive, dependent, essentially mute men described above. Another female doctor

treated a group of patients whose illness was comparatively recent and who were receiving insulin shock therapy on another ward. There were indications that many male patients were more freely verbal in relating to female doctors. Discussion of homosexual problems was less emotionally charged, although its effect on non-discussants was to arouse considerable anxiety. There was more discussion or acting out of heterosexual interests, but hostility seemed to be expressed as freely to the female doctors as to the male.

Two young male doctors, who had led or observed groups on the experimental ward during the first year of research, also treated groups of schizophrenic women on another ward. Both experimented freely in composing their groups of women and arrived at almost identical formulations. They agreed that in their limited experience:

1. Doctors and patients had felt freer and less anxious in the large groups than in the small ones. Groups of fourteen or fifteen seemed optimal.
2. The wider the range of illness represented by members, the better for group progress. The various subtypes of schizophrenia should be represented and patients should be in all the various stages—acute, chronic, and on continued treatment service. Such patients were inclined to discuss themselves and their differences in hospital status and illness.
3. The groups of women were more verbal than the groups of men, usually only one or two being non-verbal. Thus, there was a broader range of active participants in female groups.
4. The women relied much less on bodily or postural expression of feelings than did male patients and were more direct in their verbal expression.
5. Women expressed their ambivalence, on the whole, more openly than men. Female groups were characterized repeatedly by mood swings of a very intense character, as one doctor said, "Changing terrifically from one minute to the next." The suddenness of these intense emotional shifts contributed to the difficulty of handling female groups.
6. When the doctor was a male, his sex loomed at first as a barrier to treatment because of the repeated sexual advances of the patients



to the doctor. Since the initial relationships to the doctor were highly sexualized, the patients became very jealous and critical of one another. However, this fostered more intense feelings about the doctor, who could use the latter for therapeutic purposes. As a group advanced, the difference in sex between the doctor and the patients became less important.

7. The problems of leadership were different in male and female groups. In male groups, there was a constant vying for leadership. In female groups the doctor's leadership was not questioned. He was accepted as the leader and it was always expected, even demanded, that he maintain this role.

#### RELATIVE EFFECTS OF THERAPY ON ACUTE AND CHRONIC CASES

We composed one group of nine patients whose illness was of less than two years' duration and who had not had any form of shock therapy. Our intention was to make some comparison of the course of therapy with this group as against those composed of patients who had been ill for much longer. We had expected that the therapeutic tempo would be more rapid with the former group, but this point was neither confirmed nor refuted after ten months of intensive treatment and observation. The differences we observed were:

1. As a rule the less chronic patients were more accessible and more voluble, and their speech was more coherent. Thus the doctor's job was easier in that the problems of prolonged silence or obscure communication were less common.
2. Such patients engaged more readily in rivalry for group status.
3. There were more frequent references to group processes and more overt recognition of patient-to-patient relationships.
4. Open liaisons or friendships between two patients were more readily formed.
5. There was less tendency to involve the doctor in sexual fantasies, and the expression of affects did not reach the intensity frequently observed in chronic patients.
6. Patients were more openly concerned with getting well and being helped.

## SUMMARY AND IMPLICATIONS FOR THERAPY

We do not have final formulations for composing optimum therapeutic groups of chronic schizophrenic patients, but our experience indicates that the behavior patterns which the patients present in groups, considered in relation to the doctor's own patterns, provide the best criteria for composition. These characteristic patterns we call group roles. Groups may be composed homogeneously, with patients filling similar roles, or heterogeneously, with patients filling polar or constellational roles. Passive, timid, silent male patients like those described above usually fared better when placed together in the group of a protective female doctor. In heterogeneous groups they tended to retire to the group periphery and to remain unheard and inconspicuous. However, some retiring, submissive, mute patients fared well in a group composed on a polar principle, where the group also contained freely verbal and aggressive patients.

Another possibility for composing groups is one in which the members assume complementary roles, thus forming a constellational pattern similar to that of a team or crew where each performs his own separate function. Our heterogeneous group, which proved to be the most successful one, was composed on this principle. Each type of role may have a different therapeutic value, depending on how the doctor uses it. At least two types are of general value for all diverse groups in that each provides impetus to the group's therapeutic movement either directly or as a catalyst. One is the type of patient who expresses his feelings freely, intensely, and directly, especially in regard to his sexual fantasies and his aggressive impulses. Such a patient tends to provide a focus for the conflicts common to all the members. In this capacity he assumes the function of a leader in the group and maintains the interest and tensions of all the members at a level above the minimum required for effective therapeutic interventions by the doctor. Another is the type of patient who is freely verbal and responds compliantly when the doctor talks to him. Through such a patient the doctor may frequently liquidate group silences and raise issues involving withdrawn patients. Needless to say, the doctor must not become dependent on him but must use him with discretion.

Other types of group behavior may also be useful to the doctor in

different ways. A patient whose homosexual tendencies lead him to behave seductively and obtrusively in different group situations may provide a concrete example which will enable the doctor to demonstrate to the group his attitudes toward homosexuality, and a patient whose mode of relating in the group consists of joking and clowning may be used by the doctor to divert the group when anxieties seem to be disturbing. A patient who tries to form a dependent relationship to the doctor may represent to other members their own fears and wishes, and again the doctor may use such a patient in a demonstration of his attitudes. We do not know which combination of such roles, in regard to type and number, make for optimal composition. In all probability, it will vary with the doctor's own personality pattern and conscious formulations concerning both his own function and that of the group in this type of treatment.

## CHAPTER XIX

### *Problems of the Early Meetings\**

---

As explained at length in Chapter v, the early meetings of any group are of crucial importance in setting its tone and in establishing relationships that facilitate or impede therapy. Here we present some of the problems that developed in the first ten meetings of thirteen groups of chronic schizophrenics. Five of these groups were composed of patients who had had no group therapy, while eight were composed of patients reorganized on the basis of previous experience. Although we are able to describe the techniques used in dealing with various problems, in some cases we can offer no conclusions in regard to their effectiveness, since the reactions of the patients were often obscure or delayed.

The data concerning the doctors' attitudes and working concepts were derived from formal and informal discussions, questionnaires, and analyses of reports. The data concerning the patients are based chiefly on records and discussions of the meetings.

#### ORIENTATION OF THE DOCTOR

A study of the relationships between patients and doctors was recognized as basic to an understanding of the processes of therapy. Such relationships were, of course, directly influenced by doctors' concepts regarding schizophrenia and the roles that they thought they should assign to themselves and to the patients. The ten doctors in charge of the small groups were all residents with one year's experience in the hospital. At the time the groups were formed, they had had an intensive course in group therapy, but their actual experience with

\*Major contributor: Morris B. Parloff.



schizophrenics had been limited to single interviews with patients on the intake and chronic services.

Despite their inexperience, the residents were left free to use any approach which seemed reasonable to them. This was in keeping with our exploratory attitude. Since no definitive analytically oriented techniques existed for group therapy with chronic schizophrenics, there was more to be gained by allowing methods to develop from experience than from theoretical concepts, although these could not help but influence the doctors to some degree. The enthusiasm of the residents was marked. They considered group therapy a new, exciting adventure in the field of treatment and realized that it would be a valuable training experience. However, they also felt a considerable degree of anxiety about forming their first groups. One doctor remarked later, "I felt certain that I could do it, but I did not know what I was going to do." The senior psychiatrist therefore tried to give some idea of the difficulties of any type of psychotherapy with chronic schizophrenics, in order to mitigate any subsequent discouragement. In reviewing their experience the doctors reported the following concepts regarding schizophrenia and the treatment of schizophrenics that they had held at the beginning of the experiment. Although these statements were given in retrospect and therefore may contain some distortions, the doctors considered them a fair statement of their original pre-conceptions:

1. The schizophrenic patient "is an individual with a hollow sort of life; one who has never had satisfying experiences in any period of life. He has not been able to relate to others in a satisfying way. A fixed role was cast for him in his early life—usually by a rigid parent. The assumption of any other role in later life makes him feel and react like a child—in a total way. A threat is a total threat. A hostile environment is totally hostile. He has no clear definition of himself and is not able to delineate precisely where self ends and environment begins."
2. Schizophrenia is a functional and not a constitutional disorder. Schizophrenics may be helped and their behavior changed by psychotherapy.

3. Schizophrenics have the same emotions, rivalries, jealousies, and so forth, as do other people.
4. Their behavior is meaningful and represents defenses against feelings of loneliness, anxiety, and so forth.
5. They feel that they are being coerced, that something is always being demanded of them. They are therefore constantly on their guard.
6. The schizophrenic is an individual who has been fixated in his development and has never "grown up." The homosexuality found in schizophrenics is not of basic etiological importance but represents a way of relating to people in a manner which is both regressive and re-integrative.
7. Schizophrenics feel more secure with people of their own sex.
8. Schizophrenics are less lonely in a group situation.
9. The schizophrenic understands his fellow schizophrenic patients and can therefore help them, provided that he can be encouraged to participate in group interactions, which the doctor should facilitate.
10. The group situation offers a laboratory in which patients' interactions can be studied and referred to directly as demonstrating the patients' difficulties in interpersonal relationships.
11. The group gives the patient more stimuli than can be afforded in individual treatment sessions.
12. Although some patients remain relatively non-verbal, they can be benefited by discussion of problems similar to their own.
13. The group method should focus principally on generalized problems rather than specific problems. If the discussion is kept on a general plane, the patients are more likely to see the implications for their individual problems.
14. The patient will spontaneously bring up in the group setting those things which constitute problems for him.

These attitudes were reflected in the steps which the doctors took in preparing for and forming the groups. One of the immediate consequences was the practice during the first year of avoiding any knowledge of the history of the patients. When meeting with their

patients for the first time, they knew only the patients' diagnoses and the fact that they had not responded to treatment in the course of at least one year's hospitalization. However, the doctors soon found that they needed more information, especially as an aid in getting patients to speak. Some doctors carefully studied case files and then introduced subjects that were known to be of concern to members of their groups. Obscure and symbolic statements and vague allusions to individuals, without further identification of relationships, were sometimes made intelligible through study of case histories. The knowledge thus gained also gave the doctors more confidence in their understanding of group interactions and diminished their anxiety, which in turn helped to lessen the patients' anxiety.

#### PREPARING THE PATIENTS FOR THE GROUP

Before the meeting of each group, the doctor saw all the members individually, in an effort to anticipate and deal with some of the problems that patients might experience in the group setting. The doctor's attempts to orient the patient continued in the early meetings, and the following discussion is based on the pre-meeting interview and early group meetings. During the initial phase of the project many doctors made special efforts to play the role of the "good" authority figure, adopting what some characterized as a "democratic, non-authoritarian" approach. They assumed that, since schizophrenics had probably had serious difficulties with authority, they might benefit from finding that doctors, despite their inherent powers, treated patients in a considerate and respectful fashion.

In an effort to adhere to this approach, some doctors used the technique of "inviting" patients to join the groups and consulted with them about a convenient time for meetings. Both these devices were subsequently abandoned as being unrealistic. In point of fact, if a patient declined to accept the invitation, he was not excused from attendance, although once a meeting had begun he was free to leave at any time. All patients on the closed wards were brought to group meetings by attendants, and the patients with grounds privileges who failed to report regularly for group meetings ran the risk of having

their privileges revoked. Such invitations consequently came to be viewed by the patients as reminders of their own impotence, rather than as indications of their importance to the doctor, as originally intended. Consulting patients in regard to the time of meetings was similarly unrealistic, for it was soon discovered that, whereas the patients' schedules were flexible, the doctors' schedules were not. Moreover, when the doctor found it necessary to change the hour of the meetings, after having agreed to the time requested by the patients, his action was viewed as a rejection and further evidence of arbitrary authority. As a result, it generally proved best to use the frank approach of saying that patients were expected to meet in small groups. In each case the doctor would add that he wanted the patient to be a member of his group.

Difficulty was also encountered in presenting the aims of group therapy, since in many instances the patients felt that the purpose of the meetings as indicated by the doctor was inappropriate to their cases. Most patients did not view themselves as mentally ill and resented the phrase "To get you well" commonly used by inexperienced doctors. As one patient put it, "I'm not crazy. I'm just not bright." He looked about the room and added, "None of us here are quite bright." Although many of the patients were at least occasionally aware that they were ill, that the hospital was a place of treatment, and that the staff was trying to help them, they preferred to view their problems as physical rather than mental. They expected physical examination and treatment and were disappointed when it was explained to them that the doctor would merely talk with them.

The reaction to the phrase "To get you out of the hospital" depended on the patient's attitude toward the hospital. To some, discharge from the hospital represented a goal of maximum desirability; to others, it meant return to a hostile society from what had become a refuge.<sup>1</sup> Many were anxious for discharge because being hospitalized represented rejection by their families. Most of the patients had been committed or brought to the institution by close relatives, and many took this as evidence of lack of affection. It was not uncommon to hear: "My mother had me locked up. . . . I guess she hates me," or "Putting your husband in a nut house is a good way to get rid of him." Occa-



sionally one patient would express hostility to another by reminding him, "Your family can't think much of you. They sent you here." One patient complained that his wife used the hospital as a threat and that whenever he displeased her she would call the police and have him rehospitalized. "A woman who would do that certainly can't love me," he said.

To some the fact of hospitalization in a mental institution represented evidence of rejection by society and carried a fearful stigma. This attitude was reflected in the attempt of certain patients to dissociate themselves from their fellows. One patient characterized this position by describing the status of another inmate as "lower than the lowest kind of scum." He resented being identified with other patients and would explain to them, but not to doctors, that he was an employee.

Many patients urgently sought release from the hospital because they saw themselves as undergoing punishment. Those who had shock treatments complained of the severity or unusual nature of their punishment. In one group when the doctor explained that her goal was to help the patients "get out of trouble," some of the patients instantly appeared to become tense, as though this statement had confirmed their suspicions that they were "in trouble" and were being punished for an alleged misdeed. They began to offer excuses or denials of any acts that warranted such severe punishment. In one instance, following the doctor's announcement that the aim was to help the patients leave the hospital, a patient went AWOL and upon being returned to the institution explained unsmilingly that he was confused by the doctor's inconsistency, adding, "You say you want me to take off, but then you bring me back."

Those to whom the hospital was a refuge found in it a life that was simpler and less painful than that experienced in the community. One young boy explained that he was very eager to leave the hospital but wasn't ready to face the ordeal of living with his father. Another patient, who repeatedly indicated his regret that the hospital did not permit him to compete in society as he desired, subsequently said one of his greatest fears was that, if he left the hospital, he would be unable to get a job and might again be rejected by his family. Another



patient was hospitalized only after he had begged a policeman to lock him up and thereby protect him from "the voices." To him the hospital meant assurance that he could not cause or receive harm.

During the second year, therefore, the doctors tended to defer making specific statements until the aims of the patients had been clarified in the course of therapy. A typical statement of purpose might be the following: "To discuss any problem that is bothering you. It may relate to the present hospital situation, situations leading up to hospitalization, or plans for life after leaving the hospital." Increasingly the doctors tried to enable the patient to express what he wanted from the meeting rather than to impose their own goals.

In order to facilitate identification among group members, some doctors attempted to stimulate group morale by giving the patients a basis for pride in the group and emphasizing factors common to all. One group, for instance, was composed of patients who had superior educational backgrounds, another of patients who had not had shock treatments and were more or less in contact with reality.

Almost all of the original group of doctors held the view that an essentially passive role on the part of the doctor would stimulate interactions and leadership among the patients. The doctors further believed that they should not concentrate on individuals but rather focus attention on the group as a whole and act as moderators. The long-range effects of this orientation are discussed in Chapters vii and xv. It was thought that by this attitude they would dissociate themselves in the minds of the patients from the stereotype of the authority figure. Later it was found that the patients' initial reaction to the doctor had little relationship to the latter's actual character or his statement of intention but rather was strongly colored by their previous experiences. They saw him as a powerful person who represented both a promise and a threat. Nevertheless, doctors persisted in their efforts to avoid giving the patients any objective basis for these stereotyped ideas. To many patients, the doctor's most arbitrary power was his authority to decide if and when the patient was to be released; the doctor appeared to be waiting for the patient to do something that would indicate that he was eligible for release, yet gave him no clear idea as to what would be convincing evidence.

At the start the doctors emphasized the point that group members might be helpful to one another, since they had probably had similar experiences or emotions that would lead to increased understanding of the other fellows' problems. The immediate reaction, if any, to this was negative. Patients appeared to show little or no interest in one another. As on the wards, some held themselves quite aloof and others participated in transitory homosexual alliances. When patients who ordinarily isolated themselves were suddenly placed in a group in which they were encouraged to speak, it was not surprising that the interaction was usually rather tenuous. Many patients expressed dislike of associating with the others, whom they considered odd, "queer," or "nuts." Violent or "peculiar" behavior on the part of some patients accentuated the need to withdraw.

Most of the patients volunteered no comments or questions after the doctor had concluded his orienting remarks. However, in three cases, patients were outspoken in their refusal to join a group. The first expressed fear of speaking before a group, giving the excuse that he was subject to stage fright; the second questioned the wisdom of speaking in the presence of other patients, explaining that he feared his "problems would get lost in the problems of the group." The third patient offered no explanation but warned that if he were forced to attend meetings the doctor would "have trouble" with him.

#### INITIATING AND SUSTAINING INTERACTIONS

Once the group had been formed the doctor was faced with the task of getting the patients to discuss their problems, which was necessary if treatment was to proceed. His success depended on his ability to deal with the anxiety that prevented the establishment of patient-to-doctor and patient-to-patient relationships. It was therefore important to recognize that patients' behavior in the group represented in part at least the anxiety due to deviation from routine and to close association with fellow patients. It was expressed as fear, suspicion, hostility, and ingratiating and compliant behavior. Group resistance was found only as group feeling came into being.

The position taken by a patient entering the group for the first time

was frequently an eloquent expression of his initial reaction to the doctor, his fellow patients, and the total situation.\* Usually one or two patients posted themselves near the exit as if poised for flight; others sat down quietly or expectantly, perched gingerly on the arms of chairs, lay on the floor behind benches or tables, huddled in corners, stood by windows with their backs to the group, paced near the walls, or assumed a catatonic pose. Their position in relation to the doctor was found to be a useful basis for predicting degrees of verbal participation. The patients who stationed themselves closest to the doctor were usually the first to talk to him and tended to be the verbally dominant members, at least during the early sessions. Patients who had known the doctor previously, as in Group v-b, tended to sit closer to him and to speak more readily than the others. Shortly after the meeting began in Group 1 it was disrupted by a patient who was noisily playing pool. Other patients turned their backs to the doctor, pretended to sleep, read magazines, or walked out of the room. Regardless of the length of time patients had been on the same ward, they seemed to be trying to get as far away from one another as possible. There was a tendency to avoid the center of the room. If any positive relationship existed from patient to patient, it was not evident.

A diminution of discomfort is illustrated by the following incident. In one group a certain patient had remained in a catatonic pose, with his back to the wall, throughout the first meeting; at the beginning of the second meeting he took a chair opposite the doctor and remarked with evident relief and pleasure, "What I thought would happen didn't happen. . . . I enjoyed the meeting." In the second year, when groups were reorganized, the patients appeared more

\*At the Washington Mental Hygiene Clinic a group of five patients, composed of two ambulatory schizophrenics and three neurotics, habitually seated themselves around a table, so that the doctor was at the head, with one patient directly across from him, two on his right and two on his left. In discussing the significance of the seating arrangement, the patient who sat on the doctor's left explained that he did not trust the doctor and therefore sat where he could watch him without himself being observed. The patient who sat directly on the doctor's right stated that he sat there because he felt more comfortable when he did not have to face the doctor. The schizophrenic patient who sat next on the doctor's right, explained that he took this seat because he was afraid that the doctor might hit him. The second schizophrenic patient, who sat opposite the doctor explained that, since he distrusted all doctors, he wanted to sit where he could keep an eye on the doctor.

willing to sit close to one another but remained suspicious of the doctors' motives and goals. Their deep distrust was perhaps most clearly reflected in questions asked repeatedly in all five of the original groups as to the purpose of the meetings. Although the doctors had usually explained the purpose of the group to each member individually, and had repeated their explanations after the meetings began, the patients continued to ask about the "true" purpose. At the close of the first meeting of Group VII-a a patient buttonholed the observer, and, with the air of one who invites a great confidence, asked to be told the "real" reason for holding these meetings. When a patient in Group XII asked the doctor why she came to the group and the doctor replied, "To help you solve your problems," her announcement was met by jeering laughter from a number of patients, one of whom stated that it was the funniest joke he had heard in a long, long time. Another patient remarked that the doctor probably enjoyed being the center of male attention, but that if she were looking for a good time, it was unlikely that she wanted to waste her time with these men—she probably came because she was ordered to come by her superior. He advised her to return to her superior and report that she had accomplished her mission and was now ready for a new assignment.

The doctors' sincerity was frequently tested. For example, in Group V-b a patient remarked, "All doctors are insincere. Doctors are trying to learn things about foreign relationships. What trusts are they trying to break?" When the doctor attempted to assure this patient of his sincerity, the patient immediately demanded a pass from him. When the doctor explained that he did not have the authority to issue the pass, the speaker angrily shouted that he didn't like people crossing him up. In the following meeting a second patient continued the discussion by telling the doctor that "to be in the medical department you must be sincere about your work." The doctor inquired, "What does 'sincere' mean to you?" and the patient responded, "To be interested in and have a background with people, and try to mind your own business. . . . Be as pleasant as you can." Another patient immediately echoed this, "That's a true statement."

Patients tested the doctors' skill and interest by acting as spokesmen for others. This permitted the speaker to see how the doctor would



deal with another's problem before he presented his own. For example, in Group XI, a patient claimed to speak for another, who, he said, was being held in the hospital only because of his wife's avarice for the patient's pension checks. After telling this he spoke about his own resentment at being hospitalized and the part that his mother played in it.

One of the reasons why patients were fearful of group therapy was that all treatment had become associated with the shock treatments to which many had been exposed previously. The idea of treatment through discussion was completely foreign to them, and statements about it by the doctors were generally ineffectual except for those few who had had psychotherapy. In each of the five original groups the subject of shock therapy was brought up by the patients in the first meeting. In Group VII-a and VII-b, whose members had never had shock treatment, this subject was never mentioned at all.

A marked diminution of anxiety was noted in the patients in reorganized groups in comparison with patients in their first group meeting. For example, one patient in his first group meeting thrust his fingers in his ears and shouted out the window, "They signed me up without telling me. . . . I don't know why I was sent here or why I'm kept here. . . . Crazy nonsense in here. So long mister, you can look for a dead house any day now. . . ." In the initial meeting of a reorganized group he sat relaxed in a chair near the doctor. Other patients who in their first groups had stood near the door, hid in corners, or paced uneasily, in their second experience quietly seated themselves.

Hostility was of course a prominent defense against anxiety. For the purpose of our research we limit the use of the term to the overt behavior that had been agreed upon by observers as clearly indicating anger. In reviewing the initial meetings of all thirteen groups it was found that hostility was expressed toward the doctor during the first meeting in only one of the five original groups and in five of the eight reorganized groups. This difference suggests that in the course of their previous group association the patients' anxiety and fear of doctors had diminished. In some cases the resentment was the result of disappointment with group therapy or anger at the first doctor, but the



behavior of the majority indicated that their hostility was due to their viewing the first doctor's departure as a rejection. The new doctor was sometimes seen as a usurper.

The hostility expressed in experienced groups was usually direct and often took the form of belittling the value of psychotherapy and deriding doctors. In Group ix a patient told the doctor that he had frequently requested treatment but had not received it. He explained that what he desired were physical examinations and medical prescriptions. "I had a lot of faith in doctors, but not now," he added. When the doctor attempted to reply, the patient interrupted him to advise, "The first thing in keeping healthy is in not bothering them. If someone comes to you and asks you for something, he should get it." The doctor asked, "What do you want from a doctor?" The patient smiled and replied, "I've learned not to expect a hell of a lot." Another patient's annoyance was clearly indicated in remarks about the doctor's deliberately relaxed position. The patient snickered and asked if the doctor was comfortable—"Comfort is a very important thing. . . . Are you interested in everybody? Perhaps you are looking for a sucker—a fall guy. . . ." A patient in Group xii said that the group meetings were "probably more valuable to the doctors than to the patients."

After ninety-nine group meetings with Dr. Y, Group vii-a was transferred to Dr. B. In the first meeting with the new doctor, a patient asked him where Dr. Y was, as he had a pain and wished to see a doctor. Dr. B explained that Dr. Y had left the hospital. The questioner surveyed their new leader and cracked, "So you're going to take his job and be a doctor. I'll take your job as an office boy." One of the most hostile patients encountered was Mr. S, in the control ward, who was angry with the ward administrator for having failed to assign him to group therapy. When the ward administrator later formed a group, Mr. S presented himself at the first meeting uninvited. The doctor decided that it would be less disturbing to the group if he permitted this patient to remain during the session. Mr. S interrupted the doctor's attempts to orient the group by immediately demanding to know his qualifications as a therapist and comparing him unfavorably with his previous doctor. When he queried, "Do you have to have an analytic mind to be an analyst?" another patient volunteered the information

that "a psychiatrist is a psychologist who passes his tests." The first patient continued his attack, demanding to know if the doctor were a socialist—"They hang socialists! I thought they hanged the last one." When the doctor quietly suggested that the patient should consider himself an observer of the group, the latter bristled, "If you're not interested in what I say, then you say something." A silence followed that was finally broken by the doctor's comment, "Everyone is pretty quiet." The patient flashed back, "I didn't think you wanted me to talk any more. Ordinarily it's considered rude to ask a guy to talk and then tell him to shut up." He then arose, and as he strolled out of the room he called over his shoulder, "I've got more important things to do. This is probably for catatonics who like to sit around."

Hostility toward the doctor was often expressed indirectly by a display of anger toward fellow patients. As there was little interchange between patients during the first year, typical examples are drawn from second-year groups. During the second meeting of Group v-b a patient first accused the doctor of insincerity, then asked to be given grounds privileges. When the doctor said that he did not have the authority, the patient became loud and abusive, challenging "any nitwit who feels he's too damned smart." Later, when a second patient merely spoke to the doctor, the first patient immediately knocked him down.

Patients who appeared to be friendly with doctors were frequently subjected to attacks by other patients. In Group i a patient who appeared angry with the doctor subsequently denounced another patient who appeared to be compliant, describing him as one who "would do anything the doctor told him to." In Group vii-a a patient was reprimanded by a fellow patient for talking too much. The first patient merely shrugged and replied, "That's the way I am. I cooperate." In the second meeting of Group ix a patient shouted abuse at the doctor, expressing contempt for him and challenging his motives in forming the group. A second patient repeatedly interrupted the first with vague statements regarding the need for honoring and respecting parents—apparently supporting the doctor. The first patient then shifted his attention to this speaker and asked if he were "looking for a bust in the mouth."

That patients were alert to and resentful of other patients' compli-

ance with the doctor was also evident in frequent discussions of the problem of "taking sides." For example, in Group XII one patient complained that there was "too much of this question of sides, which results in friction and unrest." In Group VII-b, when the doctor asked a patient to comment on the statement of another, the first patient interrupted to observe, "He's not on your side or my side. He's neutral." In another group, when the subject of sides had been raised, the doctor asked a patient what side he was on. The patient replied, "My own side, I guess. Hurrah for me, and to hell with you."

Another source of hostility between patients was caused by rivalry for the doctor's attention. This took on increased significance as the relationships between patients and doctor became more intense. In the early meetings some rivalry was evident in the patients' attempts to appear superior to others in the group and to hold up other members to ridicule. When a member of Group VII-b announced in the group that he had observed a television show, another member interrupted him sneeringly, "That's very interesting, isn't it? Interesting conversation, huh!" Later in the same meeting the hostile patient interrupted a patient who was giving a monologue on the advantages of tea over coffee by commenting to the doctor, "Some of us here are weak-minded."

In a broad sense, compliance might be interpreted as any behavior on the part of a patient which was consistent with that requested by the doctor. Thus, the mere fact of a patient's speaking might be interpreted as compliance, and failure to speak as resistance to therapy. Patients who were compliant during the early stage of group therapy appeared to be attempting to ingratiate themselves with the doctor. Some indicated by their deferential, fearful behavior that the doctor was seen as a person who had to be appeased. Others appeared eager to ally themselves with the doctor in order to win his approval, protection, and support. These attitudes were epitomized by the statement and manner of a patient who advised the doctor, "The whole world is built upon psychiatrists. All strength comes from psychiatrists."

Although some patients looked on the doctor's "power" as a threat, others thought it might be of benefit to them, if the doctor could be persuaded to like them. Patients frequently appealed for an indica-

tion of the doctor's support by asking for favors, such as discharge from the hospital, leave of absence, or grounds privileges. In each group in which patients had had no previous group therapy, the initial speakers made such requests. In the eight reorganized groups there were only two cases in which the initial speakers asked the doctor for release from the hospital or other favors (Groups vi-b and xii). It was particularly upsetting to these patients if the doctor denied his powers, since his inability to grant favors was interpreted as unwillingness to help them. Charmer, a patient in Group xii, designated himself as "Jehovah Lord God." He desired that all things be controlled by authorities in order to enhance his security. In the second meeting, when another patient ran wildly about the room, Charmer announced that the doctor and the observer were "in authority" and waited expectantly for their intervention. When the doctor, in an attempt to be non-authoritative, and thereby to promote freer communication, said, "I am just a member of the group," Charmer demanded to know if she was really a doctor. When she nodded, he advised her in stentorian tones that she had better not deny her authority.

In some instances patients were so eager for the doctor's assistance that they offered an incentive to get this help. Thus, in Group vii-b, a patient offered the doctor "fame and fortune" in return for help—"If someone with ability and ambition spent two years in this school studying these things (the patient waved his arms to include the total group). . . , he could probably come out with some very interesting findings. The person who does that will be famous." Patients also offered their bodies to the doctor in exchange for help. In each of the groups led by a male doctor, all the patients at some time gave evidence, either by violent vituperation or by deeply submissive attitudes, of their belief that the doctor required them to submit to him sexually. For example, a patient in Group v-b, after expressing great anger toward the doctor, finally, with an attitude of resignation, unbuttoned his trousers and offered the doctor his penis.

In Group xii, which was led by a woman, a patient discussed the doctor's sex, the effect that marriage might have on her and her work, and the assets and demands of marriage. Glaring at the doctor, he said, "I'm willing," and then, in a deliberate fashion, repeated, "I am willing



to resort to what to me would be desperate measures." That his meaning was clear to others was indicated by a fellow patient's remark that it was improper to marry for money rather than personal happiness.

With increasing recognition of the group as a unit, patients began to utilize the group situation as a means of resisting those efforts of the doctor that provoked anxiety—their efforts being usually directly contrary to the mores that the doctor was trying to encourage. This phenomenon of group resistance was one of the greatest challenges to the psychiatrist's skill. For example, at the close of the first meeting of Group VII-a, during which one patient had bitterly complained about the poor treatment he had received at the hands of his mother and brother, a second patient asked the observer to intercede with the doctor to prevent the first patient from again discussing such personal material. At the opening of the second meeting two patients registered the same complaint to the doctor, explaining that "in case the subjects were all concerned with family problems it would be pretty hard to discuss them in the group." Another patient added, "It will be pretty hard for anyone other than the doctor to say anything to him."

Patients' efforts to find subjects about which they could talk comfortably is illustrated in the exchange between two patients in the second meeting of Group IX. Frasher: "What would one talk about in the group?" Hawks: "Different subjects that you're interested in." Frasher: "What topics would you be interested in? I don't have any myself." Hawks: "I wouldn't talk unless somebody else wanted to talk about the same thing." Frasher then suggested that they talk about sports or news events, "some column, some doctor's ideas, or some theory in medicine." "Then we could talk to the doctor about that and get his theory," he added.

In Group XII a patient attempted to limit the topic for discussion by asking that there be held a pre-meeting conference of patients at which subjects could be sifted out for presentation to the doctor. Others suggested that topics be limited to those concerned with hospital administration.

The rather repressive atmosphere produced by this low tolerance for anxiety was illustrated in Group VII-a, when a patient who was

fairly well integrated said that he was a "Christian Science Healer." When a second patient asked how hospitalization would affect his subsequent adjustment in the community, the first patient interrupted to advise that the best plan would be "to forget about having been here." When another patient insisted on discussing his relations with his family, the repressive patient said angrily, "A person who has robbery as his goal should study it. If he has as his goal a good clean life, then he should forget as much as possible." Efforts at repression were also used to frustrate the doctor. For example, in Group VII-a, one patient acting as group leader suggested that the other members remain silent when addressed by the doctor—"Remember, silence is golden." A few meetings later he asked them to speak at once to annoy the doctor.

These typical reactions in the early meetings represented the general problems with which the doctors had to deal in their efforts to initiate and conduct therapy. The success of the techniques used in dealing with patients was of course in part a function of the relationship which the doctor was able to establish with the patients (see Chapter xv). At the first meeting of the group, following the orientation talk mentioned above, the doctor introduced himself and usually also the patients, the observer, and any visitors that might be present. No significant effect was noted in groups in which the doctors did not introduce the members to one another, but anxiety appeared to develop when they failed to introduce themselves. For example, when the doctor who had been running Group VII-b was about to turn it over to Dr. D, the latter attended several meetings as a visitor. At each meeting he had said, "Dr. D will be the doctor after I leave." Dr. D therefore assumed that it would be unnecessary to introduce himself when he took over the group. The patients, however, clearly indicated that they felt the doctor should introduce himself. During the first meeting after Dr. D took charge they always referred to him in the third person or gained his attention by shouting, "Hey!" One patient finally asked Dr. D his name, and even though the latter replied, several other patients repeated the question until the doctor announced his name to the group as a whole. After that, patients addressed him by his name.

Although patients asked questions in regard to the observer's role regardless of their orientation, anxiety about his note-taking, as well as his presence, seemed to be diminished if he were introduced by the doctor. Some patients said that note-taking made the group sessions "too formal" and limited their spontaneity. Others expressed the fear that the record would be used by the hospital board to decide whether they were well enough for discharge. Reassurance by the doctor was not particularly effective during the early meetings, but the patients' concern gradually diminished as it became evident that the observer was not a threatening figure. However, they never seemed to become oblivious to his presence and continued to make remarks such as, "Write that down," "Strike the last remark out of the record," or "Am I talking too fast for you?"

After making the usual opening remarks and introductions, the doctors were faced with silence in all but one group, whose members had had no previous group therapy. The one patient who did talk screamed at the doctor, whom he had met for the first time: "Sewer rat! God-damned sewer rat!" In each of the eight first-year groups, patients talked to the doctor immediately. This suggests that the experienced patients were considerably less anxious and more acceptant of the association. The direct approach of asking the patients if they had any comments to offer or questions to put to the doctor was sometimes successful. This technique was more effective than that of asking the patients to respond to a roll call, although neither was apt to start any sustained interchange. Other devices found useful during the early meetings were the following:

1. Sitting or standing next to a patient was apt to induce a patient to speak. The doctor's proximity was interpreted by some as a pointed demand that they speak to him, and by others as evidence of his interest in them, which helped them to overcome their fear of speaking.
2. Quoting opinions expressed by patients in pre-meeting interviews often elicited response. When such opinions were contrary to those expressed in the group, patients usually felt called upon to expand or defend them.
3. Reassurance in regard to group immunity proved an important factor

in inducing patients to discuss personal problems. Before asking each patient in turn whether he had a comment to make or a new subject to bring up, doctors stressed the fact that all remarks made in the meeting were privileged, that all statements were confidential, and that no one would be punished in any way for his opinions. The group was told that the notes taken by the observer would be used solely for purposes of increasing the doctor's understanding, so that he could be more helpful. As was to be expected, such announcements did not always have the desired effect. A typical negative response to the doctor's efforts to assure members that they could speak freely was seen in Group XII, in which a patient remarked, "We don't always speak everything we think in society." Another patient expressed fear of speaking about personal problems, explaining that the last time he had spoken of them to a doctor he was put in the hospital. If he kept quiet now, he reasoned, the doctors might release him. When the doctor emphasized that her plan was to encourage freedom of speech in the group, a patient replied, "Freedom of speech is okay in times of peace, but in times of reconstruction you have to be careful." For further discussion of techniques used in dealing with silences, see Chapters XI and XXI.

#### FOSTERING RELATIONSHIPS BETWEEN PATIENTS AND THE DOCTOR

Each of the techniques in the list below appeared to be useful with some patients, but the doctor's underlying attitude, of which specific techniques were merely expressions, was the important factor in establishing relationships. Techniques that were used mechanically on the theory that others had found them helpful were usually disappointing in their results. One cannot speak of the effectiveness of a particular technique without recognizing that the feeling behind its application was a crucial factor. A sampling of typical techniques includes:

1. Clarification of the doctor's function in relation to ward administration. Doctors did not have the authority to release patients from the hospital, but denials that their recommendations to the ward administrator would carry weight frequently caused patients to feel that the doctors refused to accept any responsibility for them.



Those doctors who did not sidestep this issue, but used it as a subject for discussion, appeared somewhat more successful in establishing meaningful relationships with their patients.

2. Consistency in behavior and statements on the part of the doctor. As has been indicated above, statements of group mores were ineffectual. If a doctor announced that patients could talk about their problems and feelings with impunity, it was necessary that he be capable of accepting the consequences. If the doctor became anxious as a result of a patient's hostility toward him or because of the intensity and primitiveness of the sexual feelings expressed—two of the most common problems—his reaction was obvious to the patients. His lack of anxiety was equally apparent. On one occasion, when a doctor with hands in pockets calmly placed himself between two patients who were about to fight and thereby brought the incident to an abrupt close, the meaning of his earlier statements that violence would not be permitted was dramatically demonstrated. The patients were reassured that he meant what he said and the amount of personal material discussed in the group increased.
3. Offering praise and approval to patients who had complied with the doctor's explicit or implicit expectation that they speak, present personal problems, make relevant comments on the statements of others, act as group leaders, or show some insight into their own problems or those of others. This brought patients who had been praised closer to the doctor and encouraged others to emulate them.
4. Prolonged conversations with individual members of the group apparently cemented relationships between doctors and patients and stimulated others to attempt to establish similar private relationships. Rivalry between patients for the doctor's attention was intensified by such conversations, as was also the case with praise.
5. Giving and receiving gifts. It was customary to have cigarettes available for the patients. Frequently patients appeared to desire some token of relationship with the doctor and would look upon cigarettes, which they might ask for and receive, as symbols of it. In some instances patients' requests included the loan of the doctor's or observer's wrist watch, glasses, fountain pen, and so forth. When

these were lent, it was made clear that they must be returned before the end of the session. In no instances were the articles damaged. Failure of the doctor or observer to comply with a request was sometimes taken as evidence of a lack of faith or regard for him, whereas compliance was viewed as a demonstration of acceptance. One doctor placed cigarettes and candy on the table in the meeting room and announced that patients could help themselves. A particularly effective technique was that used by a doctor who, having no cigarettes, borrowed one from a patient who had launched a particularly vicious verbal attack on him during the previous hour; this illustrated that the doctor bore no ill feeling.

6. Variation of position according to an immediate aim. The practice of walking about the room from patient to patient permitted the doctor to make contacts with patients who otherwise remained on the periphery of the group. This technique was effective when the patients desired a relationship with the doctor but were fearful or reluctant to take the initiative in sitting nearer him. However, there was some advantage in the doctor's taking a regular position in the room, as patients could then select their positions in reference to him.
7. Responding to one patient by using the words and phraseology of another. This technique often provided an easy way for the doctor to demonstrate his interest in both patients simultaneously.
8. Demonstrating respect for patients. This was accomplished by such devices as apologizing for lateness or absence or asking permission of patients to introduce into the group discussion material previously confided to the doctor in private. When this was overdone, however, the patients sometimes thought that the doctor was mocking them. In one group, after the doctor and observer had been extremely careful to ask the patients' permission even in such matters as taking seats beside them, one patient volunteered the information that so far as he was concerned the doctor had his permission "to get the hell out of the room."
9. Stressing the role of the patients in treatment. This was done in order to counteract the impression that treatment was the responsibility of the doctor alone or that it was something which he im-

posed on passive patients. In the second meeting of Group VII-a one of the patients made a typical remark, "We have a neurotic symptom—psychoneurotic—it's the job of the doctor to straighten you out." The doctor responded, "You're leaving yourself out. It's not for me alone to work it out. We wish to understand, but it's also for you to understand, and for you to work on."

10. Deferring interpretation. During the early meetings the doctors found that patients felt less threatened if there was no attempt to analyze or discuss their defenses or to require them to do so. Patients placed great weight on every utterance of the doctor; at times even a seemingly noncommittal statement regarding the behavior of one or more members appeared to be interpreted as a sign of the doctor's disapproval of such acts. Although some doctors felt the need of interpretations to bolster their self-esteem and to impress patients and observers, those who resisted the temptation to make impulsive interpretations were more effective therapists. Interpretations were better grounded and more readily accepted when made after the doctor had encouraged the patients to talk and had listened to their accounts of their problems and symptoms.
11. Giving direct support. This support was evidenced by the doctor's interest in protecting his patients from verbal or physical attack, his returning to a subject raised by a patient, or giving any other signs that he remembered what the patients had said or done, their having been absent or changed in appearance, and so forth.
12. Making light of problems. Unlike the techniques described above, this method of dealing with patients was almost always unsuccessful during the early stage of group therapy. Efforts to mitigate patients' emotional disturbance by such statements as, "Things aren't that bad," "You'll feel better about this later," were apt to give the impression that the doctor did not understand the problem—else how could he make light of it? In Group XII a doctor commented at the opening of a meeting, "Everyone seems to be feeling better today." One patient glared at her and replied, "Think so? Well, in that case there's no need for me to hang around here," and left the room.

### FOSTERING PATIENT-TO-PATIENT RELATIONSHIPS

In order to promote relationships among patients and to encourage acceptance of the group, the following techniques were found to be helpful:

1. Making generalizations from one patient's remarks in the hope that others would see them as having relevance to their own problems.
2. Emphasizing similarity between problems, experiences, emotions, and so forth, of two or more patients.
3. Repeating or paraphrasing a patient's statements to clarify them for the other members of the group.
4. Encouraging mutual respect by referring questions to another patient or to the group as a whole.
5. Emphasizing the continuity of meetings by reviewing the important events of one meeting at the beginning of the next.
6. Applying general statements to the immediate group situation.
7. Discussing the relationships being established between patients—provided the doctor believes that this will not provoke too much anxiety.



## CHAPTER XX

### *Rivalry Resulting from Patient-to-Doctor Relationships\**

---

IN the course of our study of chronic schizophrenic patients two hypotheses were postulated with regard to intra-group relationships. One assumed that the maximum therapeutic benefits were to be expected when intense relationships developed between the patients and the doctor, the other assumed that therapy would be more effective if such relationships developed between various patients in the group (see Chapter xxi). The present chapter describes the specific problems which arose in the group of one doctor who based his therapy on the first hypothesis, and the clinical course of patients who illustrated these problems most sharply. For the sake of contrast we have also included situation analyses from groups conducted by doctors who used a different approach.

Assuming that the first hypothesis was correct, it followed that the doctor should strive to cultivate patient-to-doctor relationships. How to do this and to utilize therapeutically the resulting rivalries then became the main technical problem.

The primary condition in rivalry is that two or more people want the same thing at the same time. In our groups of chronic schizophrenics what the patients wanted mostly, when they gave evidence of wanting anything at all, was the interest, understanding, and special favors that the doctor could bestow. Their need for the exclusive attention of the doctor seemed greater than that of the patients in the groups of neurotics. When two or more members sought the exclusive attention of the doctor at the same time, rivalry developed. It was not, however, always expressed in the same way. Direct aggres-

\*Major contributors: Albert E. Dreyfus and David Rosenthal.

sion between schizophrenic patients was rarely or briefly shown. More commonly, while continuing their attempts to relate to the doctor, patients would attack a rival by cutting in when the latter was talking or by making some indirect or symbolic derogatory reference about him to the doctor. Sometimes they employed non-verbal expressions, such as laughing at a rival or standing in front of him to block him from the doctor. Occasionally they made definite complaints or accusations concerning a rival, but nearly always the attack was made through the doctor or in relation to him.

Since the patient-to-doctor relationship in group therapy is a triangular one, with the doctor usually at the apex, it is obviously a more intricate one than the patient-to-doctor in individual therapy. At any one time the attitudes that must be considered involve the relationship of Patient A to the doctor, the relationship of Patient B to the doctor, and the relationship of Patient A to Patient B. Whenever the relationship of any two persons in the triangle changes, it is probable that the relationship of both to the third person will change.

Since it has been doubted by some that schizophrenics can develop personal relationships of any kind, this study of rivalries carries with it the obligation to document abundantly the inference that such relationships exist. In presenting our data, we have used extensive quotations and descriptions of behavior in order to establish the nature of the relationships that we observed. We recognize that errors may have been made in selection and therefore in the inferences from them. Sometimes our inferences were based on the occurrence of events in a particular sequence in a given set of circumstances; sometimes we assumed a relationship because it gave relevance to events that were otherwise meaningless. More frequently the patients' words and actions were so pertinent and carried so much emotional charge that the relationships were obvious to doctor, observer, and other discussants.

When we formed our first groups, we had no idea of how significant rivalries were in the therapeutic process, nor did we know what attitudes to take in regard to them. The predominant opinion was that rivalries should be overcome by getting the competing patients to verbalize their feelings about one another and to understand the motivations which prompted them to behave as they did in the rivalry

situation. It was thought that with such understanding the rivalries would cease and the patients would benefit. This opinion still prevails with some of the doctors who have led our groups. In line with this treatment of rivalry, it was held that the group itself, by accepting responsibility for its own progress and by resolving in a spirit of free discussion all the controversies that arose within it, thereby advanced itself therapeutically. Doctors guided by this rationale sought to foster the acceptance of responsibility by frequently referring various issues back to the group for analysis and resolution. Such referrals usually were formulated as: "What does the group think?" or "How does the group feel about this?"

Another attitude about rivalries arose quite accidentally, as a corollary to an approach to group therapy which Dr. B employed. This doctor assumed all responsibility for therapeutic progress. He believed that his main task was to induce patients to form a positive relationship with him and that this relationship would provide its own therapeutic momentum. He did not think of or refer to the group in the abstract sense or as a unified body which could resolve issues. Each patient was primarily important in his own right rather than as a part of or spokesman for the group. Dr. B sought to bind each one more closely to himself, to exchange and share privately held thoughts and feelings in regard to experiences about which each felt keenly sensitive. He was successful in this from the beginning. However, as each patient was further impelled toward relating to the doctor, jealousy flared up with unusual intensity and in a very short time rivalries flourished and became a primary issue. The doctor did not discourage these rivalries. He continued to stress a closer integration of relationships between patients and himself. Patients finding themselves in rivalries were thereby impelled to draw more closely to the doctor for support. The latter movement in turn increased anxieties already rampant in the rivalry. Involved patients went through periods of intense emotional turbulence. Two went into sudden remission. A third improved and was discharged. This led us to think that rivalry perhaps provided a therapeutic momentum which could not be obtained in individual

treatment and which therefore provided a unique contribution by group psychotherapy. We began to concentrate our attention on this phenomenon. This chapter is an attempt to analyze some aspects of how rivalry seemed to foster therapy, and the expected effects of various techniques in handling rivalries. The data are mostly from Group v-b, which was led by Dr. B. Data from other groups will be so indicated.

#### PATIENTS IN DR. B'S GROUP

Dr. B's Group v-b was initially composed of the following patients:

1. Beaman, an aggressive monopolist, refused to come to the group after the doctor forbade him to fight.
2. Kight became involved in rivalry, developed anxiety, went AWOL, and never returned.
3. Munsey, a mute patient.
4. Murdock, a peripheral member, became involved in rivalry, without benefit.
5. Nellis, became involved in rivalry, improved, and was discharged.
6. Samuels, at first a peripheral member, took part in several rivalries, became the lead patient, and improved clinically.
7. Sansom, a peripheral member, became involved in rivalry, went into remission, and was discharged.
8. Segonia, a peripheral member, became involved in rivalry, with transitory benefit.
9. Stieff became involved in rivalry, went into remission, and was discharged.
10. Weems talked little, his anxieties focused about homosexuality; did not improve.
11. Whittel talked little, later removed from the group for experimental reasons; did not improve.
12. Worden, talked little, clowning; did not improve.
13. Zachary was freely verbal, avoided rivalries or close relationships but obtained satisfactions in commentator role; slightly improved.



## TECHNIQUES USED IN CULTIVATING PATIENT-TO-DOCTOR RELATIONSHIPS

Dr. B used the following techniques to encourage patients to form close relationships with him, leading to rivalries for his interest and attention.

1. Building on prior relationships with individual patients. Three of the patients in Group v-b had been on the open ward, of which Dr. B was in charge. They knew him well, had already related positively to him, and continued to do so from the first meeting. In a friendly, help-seeking way, they made repeated requests that they be transferred to the open ward or discharged from the hospital. This encouraged other patients to relate to the doctor in the same way, and a pattern of open expression to the doctor was laid down early.
2. Stressing his help-giving role. When a patient smilingly asked if the doctor played games, Dr. B replied, "I'm not here to play games. I'm here to help you." This remark was followed by a brief silence and then by the presentation of more serious issues to the doctor by various patients and expressions approving the doctor. In his help-giving capacity Dr. B emphasized an optimistic but realistic note. When one patient asked the doctor to take him for a walk, get him "out of here," the doctor replied, "It might be possible sometimes." The patient seemed pleased at this and laughed.
3. Relating directly and personally to each patient in the group. The doctor did this by walking about from one member to another, asking each to tell his name, saying at the same time that he was interested in the group and that the members would probably like to know about him. This encouraged one patient to ask the doctor, "Is this like your home?" Another asked his age. Another asked if he fished. The doctor talked about himself openly and honestly. Patients responded by presenting their own feelings and experiences.
4. Indicating acceptance and understanding. One patient, talking of having been crucified, shook his fist at Dr. B. The doctor said, "That's good evidence you're alive." Calmed, the patient indicated agreement. When the members of the group seated themselves on

- one side of the room, the doctor pointed this out and asked if they felt that they had their backs to the wall. The patients smiled.
5. Encouraging positive attitudes. When a group member suggested several reasons why patients wanted to leave the hospital, Dr. B emphasized that they wanted to try something better, start all over again. When another member said, "Make up my mind, doctor," the doctor suggested that the patient liked him. The patient agreed. When a third member complained, the doctor suggested that he was asking for help.
  6. Fostering the expression of actual feelings. One patient told of having returned to the hospital because there was no room for him at home. The doctor asked how he felt about this. Patient: "Not too bad." Dr. B: "I'd feel pretty bad. I wouldn't like it." The patient became quiet, pondered this remark. Another patient broke in and said that his own father had told him to stay at home as long as he wanted to but his brother didn't want him. . . . The doctor stressed the fact that although several patients might have similar reactions, they would express their feelings differently. Members expressed their feelings freely.
  7. Accepting responsibility for group mores. The doctor stated plainly that he was not there to play games and that he did not handle administrative matters. When a fight occurred, he stated firmly that there would be no fighting in the group. There was never another.

#### TYPES OF RIVALRY SITUATIONS

The rivalry situations which we observed may be usefully classified according to the position of the rivals in regard to the doctor and group: (1) one is a lead patient, the other a challenger; (2) both patients challenge each other on an equal footing, usually emerging simultaneously from the group periphery. Different considerations are involved in the treatment of each type.

The term *lead patient* does not indicate "a leader" in the usual sense. It refers rather to the patient who takes the lead in behaving according to the mores approved by the doctor. Thus, he may be the first to express his positive and negative feelings, to form a relation-

ship with the doctor, or merely to talk. In his special capacity as the representative of the doctor's aims, he comes to occupy a central or focal position in the group.\* Having a lead patient facilitates the doctor's job. Since the patient concretely represents several of the doctor's aims, the latter does not have to make general statements about what he expects from group members. Instead, he demonstrates his expectations by what he encourages in the patient—a more effective mode of communication, especially with schizophrenics.

Of the two rivalry situations under discussion, that which develops around a lead patient is much more common. The doctor's chief problem, then, is whom to select from the aspirants for this role. In Group v-b Dr. B selected a highly labile patient who verbalized freely and who sought to form a close tie with the doctor. This patient appeared to be the most psychotic, or "sickest," member of the group; his behavior was obviously inappropriate and uncontrolled, and a lobotomy had been planned for him. By accepting a patient who presented a terrifying aspect to almost everyone (presumably including other schizophrenics), the doctor could hope to demonstrate to the other members of the group that he was not frightened and could therefore protect them, that the least among them and the most hopeless was acceptable to him and could benefit, and that a close relationship to the doctor was possible, holding with it the promise of understanding and support from a person with prestige. Whether these points were communicated as such it is not known, but the fact is that other members were impelled to engage the lead patient in a succession of rivalries. Any or all of the above points may have been operative in different challenging patients.

Developing a close relationship with a lead patient held out another technical advantage to the doctor, in that subsequently, even under the most severe stresses of rivalry, the lead patient would not withdraw entirely from the group situation. This meant that the doctor could give his attention to new rivals without being concerned unduly about "losing" the lead patient—a fact which was not apparent at

\*His role thus contrasts with that of the monopolist, who behaves in a manner counter to the mores approved by the doctor and who uses his focal position to forestall the integration of therapeutic relationships.

first but which gradually became clear. On the other hand, when there was no close patient-to-doctor relationship, the patient would withdraw from active participation if the doctor concentrated his attention on another member. Thus, in rivalries where no well-integrated relationships between rivals and doctor had been established, the doctor had to be extremely careful to avoid showing favoritism to one patient, which was a delicate and sometimes impossible task.

In Situation Analysis 40 we see how the doctor, verbally and non-verbally, concentrated his interest and support on a patient who reached out to him. This intensified the patient's positive feelings toward the doctor and encouraged him to become the lead patient but aroused the hostility of the other members of the group toward the favored patient.

#### *Situation Analysis 40\**

##### **DR. B'S GROUP V-B, Meeting 57**

**PRESENT:** Samuels, Stieff, Nellis, Worden, and others

**SETTING:** The group had been meeting with Dr. B for one month. During this period the members had jealously sought the attention and favor of the doctor. Samuels, whom Dr. B had referred to as the sickest patient in the group, had frequently expressed bizarre ideas and uncontrolled rage and had required repeated visits to the acute service. At the preceding meeting he had become warm and friendly toward the doctor, talked at length in optimistic tones of getting well, and expressed many of his thoughts and feelings. Dr. B had encouraged him, and the group as a whole had seemed to enjoy the discussion. At the present meeting the patient had begun in the same way.

**EVENT:** Dr. B continued to encourage Samuels, concentrating his attention and interest on him. He stood beside him and told him that he had benefited by the group treatment.

\*The pattern of the situation analyses in Part II varies from that of the situation analyses in Part I, because the problems involved were somewhat different and also because the clinic and the hospital patients were studied by different teams of workers. Since the schizophrenic groups were relatively large, only active members were included in the lists of participants. Conclusions and tentative deductions were omitted because they could not be derived with sufficient accuracy from the material available. It was thought however that these situation analyses of the schizophrenic groups threw light on the type of problems that had come up and on the way such problems had been handled—thus stimulating ideas for study by other investigators.



**EFFECTS:** One patient openly admitted that he was laughing at Samuels. Another patient whistled as Samuels talked and reiterated an obscene word. Nellis, an unsuccessful rival of Samuels, withdrew in silence (see Situation Analysis 41). Stieff threatened to attack Samuels (see Situation Analysis 42). Samuels repeatedly thanked the doctor during the meeting, complimented him, talked of his own father, of sexual fantasies, and of his enjoyment of the meeting.

Sometimes instead of displaying hostility toward the emergent lead patient (which is not undesirable), some members of the group may react by withdrawing from active participation. In Situation Analysis 41 we see how the doctor dealt with one such patient, with at least temporary success. When the doctor recognized the problem and expressed his interest in the withdrawn patient, the latter resumed active participation in the group, expressing his hostility more openly to the member who was receiving most of the doctor's attention.

### *Situation Analysis 41*

#### **DR. B'S GROUP V-B, Meeting 57**

**PRESENT:** Same as Situation Analysis 40

**SETTING:** Nellis, who from the first meeting had sought a favored position with the doctor but had not received it, and who had greeted Dr. B with a friendly "good morning," expressed his feeling about Samuels' relationship with the doctor by remaining silent as Samuels talked and then by asking permission to leave the group. He suggested that he be transferred from group therapy to education rehabilitation, where he could profit by learning something.

**EVENT:** The doctor said, "I'm sure we'd all rather have you come to the group." He then explained that this was a form of treatment and that all members had his attention even though at times he concentrated on certain ones. He said that some had already benefited, naming Samuels as an example. "We'd like to have you stay, but it's perfectly all right to walk out." To make Nellis feel less guilty and to show that he felt no resentment, the doctor added jokingly, "Every once in a while we wake up Worden to make sure he's still with us." He then playfully tapped the feet of Worden, the jokester in the group.

**EFFECTS:** The group as a whole responded with laughter and indicated appreciation of the situation. Worden laughed and asked for a drink. Nellis smiled and said he could "go for one" too. The doctor stood beside Nellis and talked with him interestedly about money

(to which Nellis had previously referred as necessary for a leave). Samuels smiled, thanked the doctor for recognizing his improvement, and compared himself with the other patients to his own advantage. Nellis remained in the room and resentfully questioned Samuels in a manner designed to show that the latter did not know what he was talking about—"What is true?" "Do you know where the Rock of Gibraltar is?" Nellis continued to come to the meetings, subsequently making a bid for the focal position held by Samuels and challenging anyone who questioned his position.

In general it is preferable for patients to verbalize their aggressive feelings rather than express them in symbolic postures or gestures. The doctor must be particularly on guard against physical violence, which arouses anxieties in the group as a whole and deters patients from forming relationships, since the example of assault on those who were involved has been vividly demonstrated. If the emergent lead patient should be attacked physically, he might become agitated or withdrawn, in either case losing his usefulness for the group.

Situation Analysis 42 presents an instance of how the doctor dealt with the threat of assault on the emergent lead patient by another member. He successfully diverted the attention of the lead patient to himself, complimented him, and promised equal help to the upset, threatening member. This maneuver warded off a fight and permitted both members to continue in their lead and challenger roles.

### *Situation Analysis 42*

#### **DR. B's GROUP V-B, Meeting 57**

**PRESENT:** Same as Situation Analyses 40 and 41

**SETTING:** In the meeting described in Situation Analyses 40 and 41 Stieff became increasingly upset as Samuels got closer to the doctor. He mumbled to himself, paced restlessly, left the room and returned, and at one point asked the doctor about getting "gas masks to keep the dust out of the locks." At the end of the meeting, when Samuels talked directly to him, he became very agitated, challenged Samuels with the question, "Why did you talk to me?" and took off his coat as if to fight.

**EVENT:** The doctor quickly moved over to where Samuels and Stieff were standing, kept up a steady stream of talk directed toward Samuels, calling him by his first name, saying that he had done very

well today, and that everybody (signifying the inclusion of Stieff) would have a chance to benefit in the same way. He did not speak to the challenging, upset patient.

EFFECTS: Samuels kept his attention directed to the doctor, agreeing with what he was saying. The challenging patient calmed down and put his coat on. The tension which had mounted rapidly decreased just as quickly, and the group left the room quietly at the end of the meeting. Samuels continued to integrate his relationship to the doctor in subsequent meetings and maintained his focal position in the group. Stieff later challenged Samuels a second time.

A maneuver which is temporarily successful, as in Situation Analyses 41 and 42, does not insure against the situations recurring in similar form. Rather, the circumstances in which patients become involved tend to be repeated over and over again, and the doctor must expect and deal with them each time. Thus, the patient who tended to withdraw in Situation Analysis 41 did so again in later meetings and the patient who threatened to fight in Situation Analysis 42 subsequently repeated this threat. In Situation Analysis 43 we see how the doctor dealt with the withdrawing patient at a much later date, the pattern recurring as before but with greater ease on the part of the patient and the doctor in their relation to each other. The patient had deliberately stayed away from meetings, without requesting permission from the doctor. But when the doctor again indicated interest in him, he immediately reverted to his favorite-son way of behaving, now however with a trace of paranoid suspicion which he had not expressed before. The doctor avoided the paranoid aspect but deliberately responded to the implications of superiority shown by the patient's statements, as though both were aware that they had gone through this procedure many times. The patient, still unwilling or unable to relate on a different basis, again expressed hostility to the lead patient.

### *Situation Analysis 43*

#### *DR. B'S GROUP V-B, Meeting 126*

PRESENT: Nellis, Kight, Samuels, Zachary, and others

SETTING: Nellis had sought a favored position with the doctor from the first meeting, and this had led him into rivalries with Kight and Samuels. He became a peripheral member after the doctor persistently

supported Kight. He frequently missed meetings and sat apart from the main group when he did attend. Occasionally he commented in a superior way about other members.

EVENT: In Meeting 126 the doctor again indicated his interest in Nellis by asking why he hadn't come to yesterday's meeting. Nellis replied evasively that he didn't know. Then he told of having been in a "gripe session" yesterday. He showed that he was still the good boy by adding that he himself had no gripes. He showed his superiority by indicating that he knew the difference between gripe sessions and group therapy meetings. Then he asked whether the patients on the control ward had group therapy, and why didn't they? He added that many patients on the experimental ward were not in groups either; he himself had both occupational therapy and group therapy, and some had neither. Why was that?

The doctor responded primarily to the implications of superiority in Nellis' talk, refusing to take them seriously. He smiled at Nellis, said that Nellis was really privileged, "quite a plutocrat." Nellis smiled in return and began to give information about the World Series. The doctor then indicated his disinterest in this content by keeping silent and by looking about at other patients.

EFFECTS: Nellis became silent, paused, and then remarked, smiling derisively, "Samuels said in the gripe session that he wanted two movies a week on the ward." Samuels replied angrily as though recognizing the hostile intent of Nellis' remark, "What's that? Answer me!" Nellis did not respond directly to Samuels but instead turned to Zachary who also had a superior attitude to Samuels and together they discussed Samuels' wanting a "double feature." They talked of "someone upset at the Rec. Hall," looking at Samuels and laughing at their joke. Samuels sat and pouted.

Although in the above situation Dr. B did not succeed in strengthening his relationship with Nellis, he did succeed in conveying the undesirability of the latter's way of relating and in encouraging him to take a stand against Samuels, the lead patient, which was the doctor's immediate aim. This double aspect is common to most therapeutic maneuvers, and the doctor's problem is usually not whether an intervention is good or bad *per se*, but whether it does most to further his immediate and general aims. Thus, in the meeting described in Situation Analysis 43, Dr. B also helped Zachary, who had shown signs of wanting to relate to him but who was afraid of the lead



patient, to come out in rivalry against the lead patient. The doctor's treatment of Nellis may be compared with his treatment of Sansom in Situation Analysis 44.

*Situation Analysis 44*

DR. B's GROUP V-B, *Meeting 126*

PRESENT: Sansom, Samuels, Stieff, Zachary, and others

SETTING: During the early months of the group Sansom was almost entirely silent at meetings, sometimes smiling, laughing to himself, or engaging in bizarre mannerisms. Occasionally he mumbled a brief reply when addressed by Dr. B, but mostly he would say nothing. His first indications of genuine interest in group events occurred when Samuels (the lead patient) and Dr. B were having lengthy, intense verbal exchanges. At such times he would look intently and alternately at both, pace about restlessly, whistle or gesture. When Stieff was challenging, Sansom indicated unusual involvement in the situation, on one occasion remaining in the room with the doctor and Stieff (who was very upset) after the meeting had ended. On another occasion during the Samuels-Stieff rivalry Sansom said to Dr. B, "Things are getting better every day," and on leaving, "See you tomorrow." At two subsequent meetings during this period he talked more freely—at one point remarking, "I'm fascinated. It's going on all the time . . . like different things going on at the same time. I've been typing in red ink." After the termination of the Samuels-Stieff rivalry, which ended with Stieff going into remission, Sansom continued to behave in the above vein for several months, at times indicating his involvement in the group situation, especially in regard to the lead patient, at times engaging in brief verbal and non-verbal exchanges with the doctor. Samuels, in the meantime, had gone through several stormy periods, expressing intense positive and negative feelings toward the doctor and frequently expressing his resentment against other members and the doctor's interest in them.

Early in Meeting 126 two other members, Nellis and Zachary, had engaged in a smiling, oblique, hostile attack on Samuels. Simultaneously, Sansom had also given evidence of wanting the attention of the doctor too. He rose, walked around in a circle in front of his seat, and then sat down. Later he started to talk, but stopped when Samuels began to mumble to himself and question the doctor in a moderately hostile way. At another point Sansom rose, walked up to the picture on the wall, and stared at it. (Samuels is well known to all for his interest in art.) Dr. B did not press these openings immediately but

waited until he had further discussed some ambivalent attitudes being expressed by Samuels. Then he turned to Sansom and said, "Sansom is quite pensive this morning." Sansom began immediately to talk to the doctor in a voice hardly audible to anyone else, apparently expressing for the first time his feelings about Samuels.

EVENTS: The doctor maneuvered as follows:

1. He indicated that he understood what the patient was saying. When Sansom remarked, "Every time you hit cross words you're going to have a storm" ("cross words" and "storm" were actually understatements when applied to Samuels), Dr. B explained that Sansom was telling the group that people create a storm by being cross. Sansom affirmed that as his meaning.
2. He encouraged the expression of hostile feelings, remarking that cross words help—"If we feel it, we have to talk it. That's good."
3. He assured Sansom that in the group the tolerance for hostility was high and the dangers perhaps not so great as imagined. He smiled comfortingly and said, "We've weathered plenty of storms right here. Storms, gales, hurricanes, flower-pots flying. . . . Here we can take it. . . . Storms last just a few minutes."
4. He stressed the importance of understanding hostile feelings—"Cross words help. Put them together and you figure out the puzzle."
5. When the lead patient repeatedly interrupted the discussion between the doctor and Sansom, Dr. B supported Sansom and concentrated his attention and interest upon him. When Sansom told of suffering, Samuels said he was glad of it. The doctor said Samuels disliked both the doctor and Sansom, thus linking Sansom with himself in regard to Samuels. Each time Samuels interrupted, the doctor would reply to him monosyllabically and would immediately turn interestedly to Sansom.

EFFECTS: Samuels subsequently withdrew from verbal discussion, and Sansom and the doctor talked together for the rest of the meeting. Sansom presented some of his feelings to the doctor, told of having "a terrible seizure this morning, a shaking of the body." (There is no history of convulsions.) He said that his thoughts were of suffering. He referred to the homosexual feelings aroused in the group, but in roundabout terms, calling the meetings a "course in bacteriology" (back-tear-iology), talking of "not lusting dirt, although deriving a certain satisfaction from it." From this day on he continued in open rivalry with Samuels, but with considerable anxiety, until he went into remission about ten weeks later.

The preceding account deals with one of the main problems, and

one of the most difficult, in this type of treatment, namely, to get members who are ordinarily peripheral or totally silent to assume a focal role by forming a relationship with the doctor in opposition to the threat represented by the lead patient. In Situation Analysis 45, we see how the doctor encouraged still another peripheral patient to become so involved.

### *Situation Analysis 45*

#### **DR. B'S GROUP V-B, Meeting 145**

**PRESENT:** Murdock, Samuels, Munsey, Zachary, Sansom, and others

**SETTING:** Murdock had said very little since the doctor took over the group. At times he had made brief comments in response to direct questions by the doctor, but these were usually noncommittal or in agreement, as if to discourage further discussion. He frequently wore a slight smile and looked interested during the meetings but often, too, he seemed bored and sleepy. At other times he would indulge in more unusual behavior, walking along the walls around the room, playing with a chair, or writing strange things in a little notebook. The only indication of his involvement in the group situation was that during periods of intense exchange of hostility in a meeting, he would move to a point far removed from the antagonistic members. He seemed most responsive to the lead patient, Samuels, moving away from him not only when he expressed anger but also when he was warm and friendly toward the doctor. On one occasion he and Samuels engaged in a brief smiling discussion accompanied by an exchange of cigarettes, but when Samuels started a lengthy, friendly discussion with the doctor, Murdock left his seat next to Samuels and sat on the other side of the room. Dr. B, intending to show his support of Samuels, quickly took the seat next to Samuels which Murdock had vacated. Murdock gave no indication of how he felt about this. In future meetings he often sat near Samuels but, as before, when Samuels expressed rage or warmth toward the doctor, Murdock often moved away. The doctor frequently encouraged Murdock to talk in the group but without success. He linked Murdock to Munsey, the mute patient in the group, saying that Murdock was "second in command" of the silent faction. After that Murdock would often sit next to Munsey. Zachary referred to Murdock as "the undercover man" in the group. Murdock responded to these remarks with his usual detached smile, saying nothing.

In Meeting 142 Sansom had unsuccessfully challenged the lead pa-

tient, Samuels, who had in turn become angry with the doctor. Both Sansom and Samuels had then remained silent. In Meetings 143 and 144, which were essentially silent, Murdock had manifested unusual behavior. He had been sitting in the seat that Samuels always took when relating positively to the doctor, and when the doctor had addressed him encouragingly, he had replied, "I don't know what to say." Later he walked to the flower-pot which Samuels had previously made a central point of interest in the group. The doctor joined Murdock at the flower-pot, and they talked together in low tones which could not be heard by other members. The doctor announced to the group that Murdock had said he would like to have a flower on the table. He then lit a cigarette for Murdock. Samuels watched, squinting suspiciously and angrily. Then Murdock remarked, in response to further encouragement by the doctor, "Something is missing," but said nothing else for the rest of the meeting. However, he appeared restless and a little anxious. When the doctor left Samuels and sat next to Sansom, Murdock also moved away from Samuels and sat near the doctor and Sansom.

Meeting 145 began with Samuels and Sansom, the dominant rivals, sitting directly across from each other at opposite sides of the room, the remaining members lining up along the wall between them. The doctor pointed out that the others could not be mere spectators, that they too were involved. Samuels then began to dominate the meeting by lecturing Dr. B patiently, indulgently, but somewhat brusquely on the need to be "natural," advising him to heal himself, and explaining the law of gravity and the need to help and do good. Sansom did not resume his rivalry with Samuels but remained silent. The doctor moved to a seat between Samuels and Sansom, opposite the main group. Murdock rose and moved out of the main group to a seat near the doctor, meanwhile watching him intently. The doctor referred to Murdock by mentioning the content of Murdock's former remarks. Murdock then began to talk at some length of ideas he had of trying to avoid walking on people. Samuels interrupted repeatedly, sometimes speaking directly to Murdock, sometimes to the doctor.

EVENT: The doctor listened intently to Murdock, giving him his interest and attention and encouraging him to talk further. When Samuels interrupted, the doctor either referred to the content of Murdock's remarks or continued to speak directly to Murdock.

EFFECTS: Samuels became silent and did not speak during the rest of the meeting; Murdock talked until the end, despite interruptions by other members, as the doctor maintained interest chiefly in him. Murdock told of many bizarre feelings and fantasies which he never



had spoken of before. In subsequent meetings he made further bids for a focal position in the group.

A comparison of Situation Analyses 44 and 45 indicates some of the main conditions necessary for enabling peripheral members to participate actively. In each case the peripheral member showed interest and anxiety in regard to the lead patient and indicated that he wanted to relate to the doctor. Our observations suggest that without this readiness to relate, patients cannot be induced by any maneuvers to take an active part. Unless the doctor is sensitive to signs, usually non-verbal, which indicate that a patient is ready, he will miss the opportunity to encourage participation. In the above situations the signs included staring at the doctor, moving next to him, or engaging in unusual, attention-getting behavior. Dr. B recognized the intended communications and responded to them. When a previously withdrawn member of the group began to talk to him, he was able to nurse along the budding relationship by concentrating interest and attention on this patient, indicating understanding of him, encouraging him to express his feelings, and supporting him against the lead patient. Using essentially the same techniques, Dr. B was able to sustain emergent participants through extremely intense rivalries.

Even though the doctor is not hostile to the lead patient during this process, it can readily be seen that the latter will interpret the doctor's support of and interest in other patients as a rejection of himself. If this causes him to express hostility toward the doctor and the group, the doctor should support him in this expression and encourage him to form a still closer relationship. This simultaneous encouragement of positive and negative feelings is apt to induce a state of confusion in the patient that may upset him very much. Thus, his involvement in rivalries is inevitably extremely disturbing to him and probably could not be endured if he had not derived intense satisfaction from his relationship with the doctor over a long period. In Situation Analysis 46, we see what happened on one occasion when the lead patient was successfully challenged by another patient. This time he again became hostile to the doctor and group but did not express his hostility directly or withdraw from active participation. The doctor then engaged in a series of maneuvers, in accord with his usual tech-

nique, which apparently produced the confusion described above. He turned his attention to the lead patient, induced him to express a basis for his hostile withdrawal, and then accepted that basis. He permitted the rival to relate to him despite the lead patient's objections but defended the lead patient against the rival. He refused to be dominated by the lead patient but encouraged him to express his feelings further. When the lead patient became extremely disturbed, the rival expressed hostility toward him and defended the doctor.

### *Situation Analysis 46*

#### *DR. B's GROUP V-B, Meeting 186*

**PRESENT:** Samuels, Segonia, and others

**SETTING:** The early factors relevant to this situation are described below under Courses of Rivalry. Following the climactic Meetings 178 and 179 in the rivalry between Samuels and Segonia, the rivalry continued at diminished intensity, with Segonia holding his own and for the most part assuming the focal role, and Samuels missing meetings, remarking angrily that group meetings were unhealthy, or turning his back to the doctor and remaining silent.

In Meeting 186 Samuels mumbled to himself about "agreement being a comparison" and talked of Capone and Dillinger (he often called the doctor a criminal). When Dr. B asked about this, Samuels told him to keep quiet—that it was none of his business. Dr. B answered that it was, since all were affected by one another. In replying Samuels referred to fellatio, adding "That's why I sit the way I do" (back turned to the doctor).

**EVENT:** In a sympathetic tone of voice Dr. B discussed fellatio in terms of the patient's conflicts over his need to get close to others—"When we were infants, we had to suck to live."

Samuels became quiet, as did the rest of the group. Segonia hid his face in his hands. Following a period of silence, Samuels began mumbling softly to himself again. As soon as he did so, Segonia looked up, waved to the doctor, and laughed. During the next phase of the meeting Segonia did most of the talking, in his usual vein. At times Dr. B related the content of Segonia's remarks to something Samuels had once said. At one such point Segonia cursed and Samuels stirred angrily in his seat. The doctor permitted Segonia to talk to him, and Segonia brought out a lot of personal material, showing his scars to the doctor.

After some time Samuels interrupted the exchange between Segonia

and the doctor by remarking to the latter, "You just like to come in here and sit, don't you?" Dr. B replied that it was good to talk out your feelings and encouraged Samuels to do this, saying that Samuels probably had many thoughts about him and sexual activities. Samuels replied angrily that Dr. B had caused trouble every evening and then commanded the doctor to answer him. The doctor replied that Samuels had made a statement but had not asked a question.

Segonia made some hostile comments in regard to Samuels but the doctor kept talking to Samuels. Segonia said that Samuels was crazy (a very sensitive point with Samuels) but the doctor defended Samuels, denying that this was true.

EFFECTS: Samuels flushed, bounced his chair, screwed up his face, blinked his eyes, and shook in fury. He threatened the doctor elaborately. Segonia interrupted him. Dr. B asked if Segonia disliked having Samuels talk to the doctor. Segonia affirmed this, saying that Samuels talked of dissipation and accused the doctor "unjustly." He didn't see why Samuels talked like that—"If he wants to talk like that it does no good, but it does no harm. They don't talk so passionately at home." When Dr. B said that Samuels had accused him of causing trouble every evening, Segonia replied that he did not see how or why since the doctor was not there in the evening. He said that the doctor was not a homosexual, and did not look like one. Samuels did not reply to Segonia, but for the next several days he was extremely disturbed on the ward and grounds, shouting, running wildly about, cursing, and being destructive. He missed the following meeting and entered the next meeting that he attended in an angry mood. His rage subsided when the doctor again complimented him and supported him against Segonia.

Situation Analyses 47 and 48 show how the doctor may intensify the rivalry situation in groups where there is no lead patient by equally distributing his attention between two members who seek to form a relationship with him and by encouraging them to express hostility to each other.

### *Situation Analysis 47*

#### *DR. Y'S GROUP, Meeting 30*

PRESENT: Cerotti, Deems, Footen, Furnas, Grimm, Palmero, Lanski, and others

SETTING: Furnas and Lanski had begun to show evidences of rivalry for the doctor's attention approximately six meetings before the event described in this analysis. They had attempted to demonstrate their

superiority over each other, making derogatory remarks and interrupting each other. Furnas was the more verbal of the two, often acting like a co-therapist. Lanski depended more on non-verbal communication with the doctor—sitting near him, smiling and nodding knowingly at him as if they shared a secret understanding, accepting lights from his cigarette rather than from his match, or singing snatches of love songs to him. Dr. Y, recognizing the growing rivalry, made efforts to show no partiality and to appear equally attentive to and interested in each. The other patients were mostly silent. The group had previously been dominated by two members who had recently been granted leaves from the hospital and who were absent for the first time.

At the beginning of Meeting 30 both Furnas and Lanski were angry with Dr. Y, apparently because he had not granted their request for Christmas passes while canceling three meetings to take his own Christmas holiday. Lanski turned the radio on when the doctor entered. This was recognized as a hostile gesture by the verbal members and Dr. Y, who encouraged the group to express their feelings about it—"Does the group want the radio? It's perfectly all right, you know, if anyone has an opinion, to express it." A third patient observed, "It (the radio) doesn't annoy me. It annoys you!" Furnas also remarked that the radio "bothered" only the doctor and the observer. He expressed displeasure with the doctor by reading instructions which he had received from the ward nurse: "Please attend all group meetings." Later Lanski broke his silence and asked vague questions of the doctor: for example, "Is this written by Beethoven? . . . Have you ever seen Endless Caverns, where they have stalactites and stalagmites?" This prompted Furnas to point out that his aunt could speak many languages.

EVENT: Dr. Y questioned each patient successively concerning his relations with significant members of his family and the meaning of going home. In talking to Lanski he asked, "What does it mean to you to go home? Do you want to help your mother?" Lanski replied, "My mother is dead. . . . I want to help my father. . . . Lots of things around the house are worthy of my attention." The doctor asked, "Would that help you out?" Lanski said it would, as there was an "atmosphere of doing something." Dr. Y: "Is that why fellows want to leave the hospital because there is an atmosphere of doing something outside?" Lanski: "Yes, that way life is worth living."

Dr. Y then talked to Furnas, who had interrupted Lanski's account by laughing at him, and asked "What does home mean to you?" Furnas replied that he had his mother at home; he would eat, sleep, and live at home. Dr. Y repeated this and asked what there was about



home that would be helpful. The patient responded: "My feelings, being with my friends, drinking tea, buying buns, making coffee for her—(he broke off)—what I need is a wife, a companion to be around the house to help my mother." Dr. Y asked what sort of a person Furnas desired as a wife. "One who takes after my mother," was the reply. Furnas added that he was very fond of his mother. Was the doctor fond of his own mother? The patient elaborated the point by indicating that it was usual for children to prefer the parent of the opposite sex.

EFFECTS: Each patient began to indicate his hostility to the other more openly and to compete for the doctor's attention in a way that was more intense and intimate than in previous meetings. While Lanski replied to the doctor's questions with general statements of a rather impersonal nature, Furnas responded with intimate details concerning his feelings about home, duties, love for mother and friends, and his desire to be married. Lanski, who had earlier turned off the radio after Dr. Y had complied with his request for a cigarette, again turned on the radio with the result that the doctor's conversation with Furnas was interrupted. When Dr. Y observed, "Our conversation seems to annoy Mr. Lanski," Furnas seemed angry that the doctor should take cognizance of his rival. "I didn't notice Mr. Lanski. I was talking to you." Furnas then questioned Lanski directly concerning his age and confided to the doctor in a superior manner that Lanski was "only twenty-five and unmarried" and so might "become emotional about marriage." Furnas continued to address Dr. Y, becoming more emotional than in previous meetings, pleading with the doctor for understanding and acceptance, asking for assurance of his affection: "You're interested in me very much. Maybe there is someone you know who could like me? Or likes me? Does he—does she like me very much? . . . Can you interpret through me, through mental telepathy?" As Furnas spoke, Lanski, who was more comfortable with the non-verbal mode of expression, began to undress before the doctor.

### *Situation Analysis 48*

#### **DR. B'S GROUP V-B, Meeting 51**

PRESENT: Nellis, Kight, Weems, Samuels, and others

SETTING: Nellis eagerly sought Dr. B's attention from the first meeting, asking for special favors such as grounds privileges and discharge. His manner was timid and obsequious to the doctor but superior to other members. Kight also solicited Dr. B's attention and asked for discharge, but did so by complaining about the hospital, saying that

people had a grudge against him and that he felt he could not impress others as being sincere. Kight aroused much anxiety in Nellis by his attacks on authorities, taking the doctor's attention, and open discussion of personal and sexual material. Nellis expressed his jealousy and hostility toward Kight by interrupting and sitting between Kight and the doctor when the latter were talking and by complaining that he could not understand what Kight was talking about.

At first Kight did not express his resentment directly to Nellis. Instead he threatened and accused the doctor and other members, saying that he did not trust anyone. He complained of being in the way of doctors on the ward, saying that he didn't have to make up to them and that they acted as they did just to be mean. He repeatedly disagreed with what Dr. B said and questioned whether Dr. B told the truth. He complained that one patient had the impulse to kill someone, that another had called him "no good," and that another had a "romantic mind" involving his mother. He insisted that they talked behind his back and tried to get him in trouble.

Nellis had previously complained about Kight's language. During meetings which Kight dominated Nellis remained silent most of the time, but indicating resentment by his facial expression, occasionally he protested meekly to the doctor or tried to involve him in a confidential low-voiced discussion which excluded everyone else, or left the room. In Meeting 51 both patients were behaving as described.

EVENTS: Dr. B stressed that the group situation had a special significance in that all feelings expressed in it were accepted. When Kight used an obscene epithet in describing the people holding him at the hospital, Nellis said to Dr. B, "That's a rude word. Isn't that right, doctor?"

Dr. B replied that although it was not socially acceptable, in this special setting it was all right, since that was the way Kight felt. He moved closer to Nellis, between Nellis and Kight. Nellis agreed that the doctor was right. Later Dr. B repeated that the group had to accept everybody's feelings. He encouraged each patient to say what he really wanted to say and when he didn't understand something to say so. When Kight asked, "What's the difference between a Chinese doctor and an Irish, Southern, or Yankee doctor?" Dr. B answered, "I'm not sure what you mean by that."

When Nellis complained of what Kight had said, the doctor suggested, "Maybe he didn't say exactly what he meant." Nellis: "Is there anything else we could talk about besides that?" Dr. B: "Anything you'd like to bring up is perfectly all right."

Dr. B made it plain that he had no favorites. After a brief hostile

exchange with Kight, Nellis asked, "Who's your favorite ball club, Dr. B?" The doctor answered, "I don't know much about teams. . . . You mean in the group?" Nellis smiled and the doctor said, "I have no favorites." Kight interrupted, "What's that got to do with shock treatments?" Nellis: "Nothing. I talked to him" (indicating the doctor). Kight: "He said you asked me." Nellis ignored Kight and turned to the doctor again: "You have no favorites?" Dr. B: "No."

After another hostile exchange Nellis and Kight stared angrily at each other. The doctor said that both Nellis and Kight had good points, that all could "get there" but that they had to trust one another.

EFFECTS: The hostility expressed by these rivals increased in intensity as the meeting progressed. Each tried his usual ways of relating to the doctor in order to cut out the other. Both became anxious. Kight persistently talked on subjects which upset Nellis. Nellis interrupted Kight repeatedly, telling him that he could leave the meeting. At the end of the session a very tense exchange between them occurred concerning Weems, who had homosexual tendencies and whom Nellis, Kight, and others had attacked in previous meetings. Kight: "No' one in here has respect for Weems. I try to have respect for him. They don't, so I don't either. For his church." Nellis: "What do you mean by respect? What church?" Kight: "You are two-faced." Nellis: "Weems is three-faced." Kight: "You are three-faced." Nellis to Dr. B: "It isn't right what Kight does in the group." Kight: "I have respect for Weems. Why shouldn't Nellis?" Nellis: "Sometimes Kight goes east, sometimes west."

At Meeting 52 both patients agreed that there was need for teamwork but in subsequent meetings the rivalry again become overt. Two weeks after Meeting 51 Samuels asked for and was accorded the special attention from Dr. B that Nellis and Kight were struggling for but could not obtain. Although the rivalry continued for a while, it gradually dwindled in intensity. Nellis continued to relate to the doctor as before, now trying to demonstrate his superiority over Samuels as well as Kight. After one such meeting Nellis went AWOL. Kight also followed his previous way of relating to the doctor but gradually became more upset as Samuels formed a positive relationship with the doctor. After one meeting in which Kight engaged in a homosexual flirtation with Weems and an attack on Samuels, he expressed intense self-depreciation and hostility to the doctor. Following this, one week after Nellis went AWOL, Kight went AWOL too and did not return.

One week after Kight went AWOL Nellis returned to the hospital, and in his first meeting he expressed intense anger against the group and the doctor. He read aloud to prevent any discussion in the group,

and when questioned by the doctor he spoke up in a loud, firm, aggressive voice which he had never used in the group before, saying that he was afraid of no one and would knock anybody on his ass (note the affect and the language, which he had never used before) who tried to scare him. He said he didn't know what charges they had against him—why didn't the doctors leave him alone? Dr. B accepted Nellis' feelings by agreeing and offering encouragement. "I don't think you're wrong, Joe. With a little help you can make out." The patient calmed down and became friendly to the doctor and talked about the attitudes of society to a patient who had been in a mental hospital. For this reason the authorities had better not keep him here too long. He had tried to get a job, but it was difficult to find one, even washing dishes. He said he had learned that money was the root of all evil. He talked about his fantasies of having a car, money, sitting all day smoking cigars, having a big house and a colored servant. He said that what he needed was a wife. He had a girl in mind but she probably wouldn't marry him. He dominated the entire meeting in this way.

Samuels, who had become a lead patient, was silent and withdrawn. The doctor, noting this, began to relate the content of Nellis' remarks to previous remarks by Samuels. Samuels said, "That's taking advantage when others are not looking." In the next meeting Nellis began to talk of further ambitions. Samuels interrupted to present his own content. Nellis and Samuels then engaged in a polite contest for the focal position in the meeting, with Nellis winning out in this meeting, but the doctor concentrated his support primarily on Samuels. For example, when Nellis remarked that Samuels was going around in a circle, Dr. B replied, "I don't think so." Nellis to Samuels: "May I ask you a question, Samuels?" Samuels: "What is it?" Nellis: "What is the largest country in the world?" Samuels: "China." Nellis, skeptically: "Maybe." Dr. B supported Samuels.

In the next meeting Nellis talked of boxing matches, saying that there were rules in boxing. Dr. B replied that there were rules in group meetings too and that every member had equal rights. Samuels began to dominate the meeting in his usual way, speaking in friendly, grateful terms to the doctor. This time Nellis expressed his hostility openly and directly to Samuels, addressing him sarcastically as "Mr. Samuels" and asking him questions designed to show Samuels' ignorance or foolishness. Samuels replied to him directly in a quiet voice. Dr. B told Nellis that he was apparently "picking on" Samuels because he thought the doctor liked him. He said that he did like Samuels, but that he also liked Nellis.

After this meeting Nellis withdrew from open rivalry with Samuels



and became less active in the group. His interests were concentrated on outside activities, and ward administrators reported on his improvement. He received passes more frequently, and six months later was discharged from the hospital as improved. He has since made a satisfactory adjustment outside the hospital.

In Situation Analysis 49, when the doctor turned his attention away from budding rivals to peripheral members of the group, the rivals lost interest in each other.

### *Situation Analysis 49*

#### **DR. Y'S GROUP, Meeting 31**

**PRESENT:** Same as Situation Analysis 47

**SETTING:** The relevant antecedents are the same as those described in Situation Analysis 47, which dealt with Meeting 30. In the early portion of Meeting 31 the rivalry between Lanski and Furnas continued unabated. Lanski opened the meeting by speaking with Dr. Y for five minutes about military government, leadership, and so forth, until Furnas entered. Dr. Y then reviewed the meeting up to that point, switching his attention from Lanski to Furnas when Furnas asked permission to take off his coat. The doctor asked, "I wonder what it is about guys who have to ask permission?" Lanski quickly responded, "It shows lack of initiative," adding that it was "kid stuff." Furnas curtly responded, "I don't have any initiative to be aggressive." Later, Lanski joined Furnas on a settee which was next to Dr. Y, so that both rivals now sat together, close to the doctor.

**EVENT:** Dr. Y altered his tactics of the previous day, when he had related with equal interest to the rivals, and now gave his attention and support to other members, which appeared to offend the rivals. Cerotti had pointed at Grimm and made a remark about him which intimated that Grimm was insane. Furnas laughed at Cerotti, explaining that it was the doctor's job to decide that. Dr. Y then turned to Furnas and asked him why he objected to other patients' mentioning their observations about one another. Furnas stiffened and his tone became angry as he replied, "It's the doctor's job. Don't you have 'Dr.' in front of your name?" Lanski became angry when Dr. Y twice moved away from him to be closer to other patients. Shortly after Lanski moved to a settee closer to the doctor, the latter moved across the room to Grimm. Later Lanski followed the doctor and sat next to him. Dr. Y again moved across the room, this time to Cerotti. Lanski thereupon turned his back on the doctor, threw down the cigarette

he had just obtained from him, kicked it, and walked to the opposite end of the room from him.

During the remainder of the hour the doctor addressed himself primarily to Cerotti, Deems, Footen, Grimm, and Palmero.

EFFECTS: Furnas kept silent except to comment hostilely at the close of the hour that the doctor was "trying to analyze what's going on." He added, "It breaks my heart when they put you in here." Lanski responded curtly to one of the doctor's remarks but otherwise remained silent for the rest of the meeting.

In the next meeting both patients were initially silent. When a visiting doctor entered, Lanski greeted him warmly, but when the visitor redirected him to Dr. Y, Lanski replied that he couldn't hear the doctor. Dr. Y questioned him directly and he repeated, "I can't hear you." He then resumed playing the radio. When Dr. Y spoke to Furnas, Furnas made brief, hardly audible replies. Dr. Y: "What seems to be going on in the group?" Furnas: "Perhaps you can observe the group." Dr. Y asked Furnas if he was "uneasy." Furnas: "No, there's nothing I have to say." Dr. Y then turned his attention to other patients, but the group was mostly silent—Furnas and Lanski ignoring each other and making no effort to secure the doctor's attention. This abatement of the rivalry lasted for some time.

In Situation Analyses 47, 48, and 49 the doctor seemed to determine the course of rivalries in large part by the way he distributed his interest and attention. This would imply that when the doctor referred the rivalry to the group for resolution, he discouraged it, and did not permit the rivals to form a close relationship with him. In Situation Analysis 50 we see one instance of what happened when the doctor used this technique: The group characteristically failed to deal with the rivalry. The rivals displaced the doctor, serving as competing therapists to a third patient. Sexuality, which the rivals feared, was brought up despite their efforts against it. Anxiety in the form of hostile reactions toward the rivals and playful tittering spread through the group. No close relationships between doctor and patients existed to contain it and direct its expression. The rivals settled nothing and became more anxious; one tried to get closer to the doctor, but was not accepted on this basis because it was the doctor's policy to refer all problems to the group for discussion and decision, rather than to become personally involved with members reaching out for support. This patient, having no support from the doctor, was never able to

bring up his sexual fears in the group. The rivalry disintegrated and both patients reverted to acute catatonic patterns.

### *Situation Analysis 50*

#### *DR. J'S GROUP, Meeting 71*

PRESENT: Ames, Brink, Brindel, Berg, Dobbs, Handen, Meynert, Cursey, Rutherford, Sands, Stole, and others

SETTING: Dr. J was rather passive, permitting the patients to structure situations themselves. His technique was primarily one of encouraging free discussion. This was frequently done by asking what the group thought about a patient's behavior or by pointing out what he thought was implied by it. This group contained several members who were freely verbal, but no single patient arose as a group leader, since the doctor discouraged assumption of such a role. There is no evidence that any close relationship was formed between patient and doctor or patient and patient, and hostility was expressed in many ways toward the doctor.

Cursey had taken a focal position in the group almost from the beginning. He frequently indulged in posturing and manneristic behavior, and at times engaged in self-destructive acts. Much of his conflict was around religion and sex. He always spoke for religious doctrine as a faithful adherent and believer and avoided discussions of sex in personal terms. He joked and clowning repeatedly, disrupting serious discussions, but never expressed anger. He seemed to enjoy the group meetings and after some time announced that he wanted to be the leader of the group. This announcement fitted in with his behavior, which seemed to be in large part an attempt to block the free discussion that the doctor encouraged. By taking the lead, Cursey could control the discussions and rule out the anti-religious and sexual talk which disturbed him. He announced that he had been a leader in several of his college groups and was therefore well qualified.

Berg was a large, imposing-looking patient, in relatively good contact most of the time. Early in the group's history he had been a peripheral member. As group meetings made him anxious, he was frequently absent. When he attended he almost always appeared (perhaps feigned) to be reading or sleeping and almost never talked. Sexual discussions upset him but he never expressed his resentment against such talk. As his anxiety increased after he was induced to attend the meetings, he concentrated all his efforts on getting out of the hospital. After Cursey had put in his bid for leadership, Berg, apparently upset by Cursey's bizarre speech and behavior, became

vulnerable, trying to cut Cursey out and appealing to the doctor for a discharge. A contest ensued between Berg and Cursey which lasted for many meetings. The doctor concentrated on getting the rivals and the rest of the group to discuss the basis for their behavior and thus resolve the issue, but this goal was not reached. Berg became compulsively talkative, preventing any discussion, and Cursey, apparently frightened of Berg, vacillated between engaging in strange repetitive behavior and making barbed attacks on Berg.

In Meeting 71 Berg began by suggesting that Rutherford, a patient whose speech was highly symbolic and difficult to understand, wanted to talk. Cursey quickly interposed and with unusual directness talked openly of the struggle between Berg and himself for the leadership of the group. He suggested a compromise, that the leadership be rotated among the various members. Berg did not interrupt Cursey and made no attempt to monopolize the discussion. However, he again opposed Cursey with the answer that the doctor was the only leader in the group.

EVENT: Dr. J, in accord with his usual technique, was noncommittal. He referred the issue to the group, asking what the members thought.

EFFECTS: No other patients ventured an opinion. Cursey and Berg restated their positions. Rutherford talked, as Berg had suggested, about his sexual fantasies. Cursey began to question Rutherford in imitation of the doctor. The doctor also addressed Rutherford in his usual style. Berg cut out both the doctor and Cursey, questioning Rutherford and making suggestions. Cursey began quizzing another patient, Handen, in doctor-to-patient fashion, contesting the exchange between Berg and Rutherford. Members began to titter as Rutherford's sexual fantasies were more clearly described. Some of the silent members grinned knowingly but anxiously. Brindel and Sands held hands. Both Cursey and Berg tried to steer Rutherford away from his sex theme. Brink became upset and angrily attacked Berg. Cursey quickly supported Brink. Brink turned on Cursey. Then Brink, Berg, and Cursey had a three-way argument. Cursey began to talk to the more peripheral members in leader fashion. Ames told him, "If you'd attend to your own business, you'd get along better." Berg turned to the doctor for support, asking what he thought of Rutherford. The doctor told Berg to bring up his own problems and, turning to the group, asked the members what they thought of Berg. Berg repeatedly tried to talk to the doctor in confidential tones, but the doctor rejected this basis for relationship, because it excluded the rest of the group.

In subsequent meetings Berg became hyperactive and hypertalkative, engaged in bizarre behavior, and several weeks later had to be



transferred to the acute service in a catatonic stupor, which lasted for months. While he was recovering from this catatonic phase, he told the ward doctor that he had not been able to tolerate the homosexuality going on in the group. (There was never any overt homosexuality in this group, but Berg's statement indicated how many, if not all, of our patients viewed the group situation.) Cursey relinquished his bid for leadership and became a peripheral member. The doctor eventually changed his technique, assuming a more active, directive leadership and encouraging closer relationships with patients who reached out to him. His later style of therapy proved to be more helpful to patients.

### COURSES OF RIVALRY

To show the ways in which contests for the doctor's attention developed and were resolved, two accounts of rivalry are presented in considerable detail. In the first, the member who challenged the lead patient went into a sudden remission. In the second, the challenging patient, after defeating his rival, apparently found the resulting closer relationship with the doctor too anxiety-provoking and returned to his previous pattern.

#### *Course of Patient Stieff*

Stieff had had four remissions after hospitalizations of three, four, eleven, and six months. This last hospitalization, however, was for eighteen months.

While the group was meeting with Dr. Q, Stieff was one of the more prominent members. Although he did not often talk at length, he made scattered comments about himself, his family, and the group situation. He was frequently agitated, aggressive, and anxious and spoke rapidly. On the ward he would suddenly strike other patients (almost always these were group members). Twice he fought Samuels, whom he subsequently engaged in rivalry. He appeared to regard the group meetings as sexually threatening and frequently manifested guilt about talking in the group or about engaging in a positive relationship with others.

In the early meetings with Dr. B, Stieff was a peripheral member. He was almost entirely silent; often he sat quietly reading a magazine and occasionally mumbling to himself. This behavior continued until Meeting 57, in which Stieff again became agitated, apparently because

of the relationship between Samuels and the doctor. While Meetings 58-65 were in session, he spent most of his time outside the meeting room. In Meeting 66 he was obviously in conflict as to whether he should stay in the room or leave. He would come to the doorway, look in, laugh, and walk away, sometimes mumbling to himself. In Meeting 67 he joined the group for a while but left the room after the doctor had made a reference to him. During this period the relationship between Samuels and the doctor was the dominant one in the group, with Nellis and Kight most openly expressing resentment against it. Samuels had been very positive at first but had now begun to express hostility toward the doctor, although moderately. Stieff stayed in the meetings more frequently but spent his time sitting in a corner, usually looking at magazines. In Meeting 71, when Samuels was very optimistic, expressing appreciation to the doctor for the help that he had received, Stieff was very attentive, remained seated, but said nothing. By Meeting 72 both Kight and Nellis had gone AWOL. This was discussed in the group, especially by Zachary. Samuels was silent and Stieff a little restless. In Meeting 73 his behavior was unchanged.

In Meeting 74, during which Samuels again showed warm feelings toward the doctor, Stieff's behavior changed markedly. Dr. B divided his attention between Stieff and Samuels, being careful not to antagonize Samuels but at the same time encouraging Stieff to verbalize his feelings. Samuels continued to be friendly to the doctor, but Stieff was extremely labile. Dr. B was very active, moving about freely, standing between the patients when violence threatened, or standing next to one patient and then the other to foster the expression of positive feelings. Stieff was mainly concerned with Samuels and the doctor, especially in regard to what was expected of him in the group and what he himself wanted. He expressed optimism, saying, "I'd like to get out of here—I'd like to go somewhere where I could get well." Dr. B said, "Maybe you don't have far to go, Stieff." Stieff replied, "I don't, as far as that goes. I think the balance is in my favor." Dr. B: "I'm sure it is." Stieff, however, was concerned about talking in the meeting, saying that, although he didn't feel he had to talk, the "problem" was one he had to settle. He said, "I don't have no right to get into anything I don't understand especially where people are concerned. People here are old, fifty-five, sixty. I don't want to be on the wrong track. . . . I've got a long time to live, one hundred maybe, that's why I want to get straight." The doctor encouraged him, saying that they had found some of the answers for Samuels and would find some for him, too. Stieff replied that he "couldn't stand the pace . . . couldn't stand the people in the place." He wanted friendships,

but there were no friends to be found at that particular moment. (This apparently referred to his not being able to keep up with Samuels, who had taken the lead in forming a relationship with the doctor, which was what Stieff had failed to do because the doctor was devoting his attention to Samuels.) Samuels continued to be friendly to the doctor, following the latter's lead in regard to Stieff and making several suggestions to Stieff as though to help him. This antagonized Stieff, who asked, "Since when did you get to be doctor?" Once when Samuels talked to the doctor, Stieff walked over to Samuels, his tone challenging, and said, "Until I met you I never masturbated." He accused Samuels of costing him respect. Samuels started to rise and reply, but the doctor stepped between them, diverting Stieff's attention to himself. Later, when Stieff talked of "getting bumped off" and committing suicide, he suddenly pointed accusingly to Samuels and said, "That's why." He expressed guilt in regard to the group, saying that the illnesses of the others were a result of mistakes that he had made in the past. Pointing out Sansom in particular, he insisted, "The longer they're here, the longer I'm here." He accused Weems, whom he had thought of as a homosexual, of making "sexy gestures in front of a woman," and was very angry about this. The doctor said that Weems had upset many fellows here, and Stieff explained that maybe it was Weems' background. He then told of his own experiences in childhood which, although not clear, were obviously connected with sexual conflicts. Both Samuels and Stieff appeared to derive satisfaction from the meeting, Samuels thanking the doctor at the end, and Stieff saying, "I'll be here Monday."

In Meeting 75 Stieff continued as before. He appeared to be extremely upset by Samuels, repeatedly accusing Samuels of having done things to him. Samuels continued to show a warm attitude toward the doctor, and this apparently upset Stieff further. Dr. B devoted his attention to Stieff, who became extremely anxious and repeatedly left the room. Whenever Stieff left, Dr. B would turn again to Samuels, explaining that he had to treat Stieff because he was very sick. Samuels agreed with the doctor. Despite Stieff's repeated accusations and threats of violence against Samuels, Samuels "ignored" Stieff and continued to talk to the doctor, enjoying himself very much. At one point when Stieff said to the doctor, "Let me tell you a story," Samuels interrupted by shouting and laughing, and Stieff was unable to tell it. Later Stieff said that he shouldn't be at the hospital, but that there was no use crying about it. He showed the doctor his muscles, insisting that he had to look out for himself. Dr. B replied that he too would look out for him. Stieff, however, preferred to be

independent of the doctor, saying, "You haven't done me any good. . . . I ain't asking for it." He said he was not afraid of Dr. B and asked if the latter thought he had all the power. However, it was evident that Stieff had reservations about this attitude, since he added, "Maybe you know what you're doing." He was ambivalent about the outcome, saying on the one hand that he did not think he would go wrong any more, and on the other that "the ship is sunk." When the patients were being assembled for the next meeting, Stieff could not be found. His whereabouts were unknown until that evening, when he was found hidden under a pile of sheets in the clothing room, where he had stayed all day rather than come to the meeting.

Nellis returned from his AWOL, and in Meetings 76 and 77, while Stieff was absent, he resumed his rivalry with Samuels. Stieff was brought to Meeting 78, and although quite upset, remained silent while Nellis openly expressed his hostility to Samuels. Samuels, however, was not upset, and the doctor supported him against Nellis' attack. Although Stieff continued to be anxious and restless during the next few meetings, he calmed and cleared somewhat and was given grounds privileges the following week-end. During Meeting 83 he remained silent except to confirm the doctor's remark that he had received grounds privileges. Dr. B complimented him on his improvement and said that he thought all the patients in the group would eventually get to the same point, but that it would take time. Samuels dominated the meeting, expressing mixed feelings to the doctor.

During Meetings 84 and 85 Stieff talked at two different points. Each time his speech was clear and well-phrased, his affect direct and appropriate. However, he still showed some intolerance for the group and left the meetings repeatedly for long periods. In Meeting 86, when Dr. B was discussing the various members of the group, he said that at one time Stieff had challenged Samuels but that he really had had nothing against Samuels. Stieff got up and left the room, saying nothing. Stieff's wife visited him during the next two days following this meeting.

In Meeting 87 Stieff again appeared in an agitated state. His speech was no longer well organized. Samuels was very angry, and both patients took turns in attacking the doctor, each interrupting the other. The atmosphere was charged. Samuels asked, "What's the tenseness in here? Is it fear?" Stieff answered that he could take care of himself. Samuels said that he wanted to see the skeletons of his parents hanging from the ceiling. Stieff rapped the table with his fist and interrupted a discussion between Samuels and the doctor, asking, "What's the matter?" Then he said, "Excuse me, I don't feel so well this morn-



ing. I've been hurt." Samuels said that he wished the meeting were over. Stieff talked to the doctor about leaving, going "over the hill," getting independence, not being trusted. He seemed to be upset by homosexual feelings, talking of "changing bedtime hours." He said, "If you want me to pay the supreme penalty, I want to know why. I want to know how things stand. Why shouldn't I give up hope? Days are short." He added, "You know what you're doing. Sometimes it doesn't appear just that way." The doctor linked Samuels and Stieff together by saying that both were telling him the same thing. Samuels denied this, saying it wasn't true. Stieff clapped his hands and laughed. He said, "Some relative made a play with me, my brother. I wouldn't have it that way. It isn't fair . . . very difficult." (This statement might have indicated that Stieff likened rivalry in the group to sibling rivalry.) Both patients related destructive fantasies, interrupting each other. Stieff said angrily that either he or the others would have to go, saying, "Every mouse wants my bit of cheese." He suddenly turned on Weems and cried, "I hate you, understand?" Then he felt guilty, talked of his conscience, and said, "I didn't cause any war." He paced anxiously back and forth, saying, "I'm getting pushed around. I'm on what they call my last leg. It's a case of—just a case. I have my own ingeniousness." The doctor replied, "You feel you might be afraid." Stieff's speech then became completely disconnected and rambling, dealing primarily with sexuality and being controlled. Dr. B devoted most of his attention to him. Samuels asked in annoyance, "How long are these meetings supposed to last?" The doctor answered, "They only last an hour. I'm trying to help Stieff here." Samuels replied resentfully, "Oh, yeah?" Dr. B said, "I think you have helped him yourself." Samuels rejected this, saying, "You don't make sense to me." Stieff told the doctor, "You want to make this the hub, the center of everything." Samuels demanded to know what a hub was. Stieff said, "My brother built one of the first radios in our town." He talked of being forced to smoke a cigarette, saying, "That's what I mean by drawing me away from my family." He talked of struggling, of helping, and of being helped. When Dr. B announced that the meeting was over, all the patients remained seated. Stieff said that he would stay "until every face leaves." The doctor again dismissed the group. This time all the patients left except Stieff and Sansom, the next patient to rival Samuels. After a pause, Sansom said to the doctor, "See you," and left. Stieff remained seated, talking about the place he was in. He said that if he were to do what was right, he would forget everything that had happened here, every pledge. "But I won't do it. That ain't right." The doctor remained with the patient until he left.

In Meeting 89 Stieff continued to behave as on the previous day, speaking almost continuously in a rambling fashion. Samuels began to attack the doctor, but Stieff laughed at him saying, "We all like jokes. Life is nothing but a joke." Dr. B said that it was a painful joke sometimes. When the doctor was called out of the meeting, Stieff followed him, asking if the doctor were quitting on him. Dr. B said, "No." When he returned, Stieff followed him into the room and stood near Samuels, who turned his head away. Stieff sat down again and said to the doctor, "Care more for me." Dr. B walked over to Stieff and repeated his disjointed speech. The patient's expression changed from laughing to very grave repeatedly and rapidly. He talked of "learning to swim all over" and asked, "How long will a life last?" He told of his childhood, of having big curls, of his father and grandfather, and some of his family history. Samuels closed his eyes as Stieff talked. Stieff went over to Samuels, stood beside him, returned to his own seat, then walked over to Samuels, making punching gestures with both hands. Samuels kept his eyes closed. Stieff smiled; he then said that he had hit Weems once and put him on the floor, and that Weems had had a habit once, but not any more. He asked, "Why not be friends instead of enemies? Let's get out of here." He talked of his marriage, saying, "My whole heart and my whole life went into it." Yet he felt that "the right and the wrong" had been married; his wife shook him up and was very upsetting.

Later that day he appeared confused and walked into the shallow water of the bay. His privileges were revoked. He was absent for the next two meetings. When he returned to the group, his behavior was changed. He sat still, read a paper, and refrained from talking in the meetings. He seemed to have gone into remission, repressing much of his group experience. In Meeting 94, one of the last which he attended, Dr. B asked him what his feelings were about what was going on in the group. Stieff said, "There doesn't seem to be much going on here." The doctor asked, "Why not?" Stieff replied, "I don't know." The doctor continued, "The reason I'm asking you is that I know you don't like these things (homosexuality) just as Samuels doesn't." Stieff asked anxiously, "Don't like what?" His tone was very defensive. The doctor replied, "You don't like Weems. You told him that." Stieff did not reply to this question, but was obviously made very uncomfortable by the doctor's statements and left the room. Shortly afterward he received a leave from the hospital, from which he was eventually discharged. He has now been out over a year, and although living with his family, who disturb him, he is said to be adjusting fairly well.

*Summary.* Stieff was labile, concerned with homosexual feelings, and expressed aggression toward other patients but not to the doctor. He moved into rivalry with Samuels (who was very friendly toward the doctor) and involved him in sexual fantasies, saying that Samuels had done things to him, made him masturbate, and cost him respect. He expressed hostility toward Samuels and vacillated between asking Dr. B for help and declaring his independence of him. The doctor supported him. In his final period of agitation, Stieff acted out an attack against Samuels, smiled, and said that he had "laid low Weems" (his homosexual impulses). With this done he could then say, "Why not be friends instead of enemies? Let's get out of here." Following this he repressed much of his group experience and went into remission.

### *Course of Patient Segonia*

About the time the group began to meet under the direction of Dr. Q, Segonia became very agitated. For the next few months he was uncooperative and combative and was repeatedly given hydrotherapy. Then he was given a short series of electric shock treatments, which upset him still more. When he attended group meetings, he remained on the periphery, at times indicating his anxiety. After four months his agitation subsided.

When Dr. B took over the group a month later, Segonia immediately became one of the three members who competed for the doctor's attention. He talked rather freely and repeatedly asked the doctor for help in getting a discharge from the hospital. His manner was that of a little boy asking his father to protect him and do things for him. When others were hostile toward the doctor, he was upset and offered to help and protect him. At first Dr. B did not discourage this behavior but after several meetings he ignored the advances of the patient, who began to express mild hostility, indicating his attitude toward the doctor by sitting on the floor and wailing, "Mommie." The doctor did not pay serious attention to him on this basis but devoted his interest to Samuels, who was beginning to emerge as the lead patient in the group. Segonia withdrew gradually from any verbal participation for the next several months. When he did speak, it was usually to make a hostile comment (e.g., that he wished the hospital would be flooded away).

He complained of being mishandled by the attendants and of having nothing to do but wait and fear; told Dr. B that he stank and ordered him to stop asking questions; or just swore and mumbled angrily to himself. When the doctor approached him, he would some-

times jump up and walk away as though angry and afraid and sometimes behave in a mischievous and coquettish fashion. For the most part, however, he appeared withdrawn, preoccupied, depressed, and apprehensive. Much of his behavior seemed to be directly associated with the relationship between Samuels and Dr. B. Once, when Samuels attacked the doctor, Segonia left the room and remained outside in the hall, occasionally looking in. At another time, when Samuels became angry with the doctor, Segonia remained in a squatting position against the wall behind the doctor, smiling to himself. After another meeting in which Dr. B successfully managed Samuels' hostility, Segonia came into the room and referred to the doctor as "dear." Shortly after Meeting 123 he took a seat at Dr. B's invitation and began to talk in a giggling fashion about Samuels, saying that Samuels was crazy and that he must be sore about something. The doctor denied these statements and engaged Samuels in discussion during the rest of the meeting. Segonia remained quiet.

In Meeting 141, during a hostile exchange between Samuels and Sansom, Segonia began to tremble. Dr. B asked Segonia if he were afraid that something was going to happen to him. Segonia repeated his negative reply several times. At one point during the meeting he suddenly turned to the doctor and asked angrily, "Well, what's on your mind?" Later he gestured as though he were machine-gunning and said, "You did it. . . . Somebody making me chatter." As the rivalry between Samuels and Sansom continued, Segonia's trembling increased to an almost convulsive shudder, his teeth chattering incessantly. He kept changing his seat, moving close to the doctor, then moving away from him. At the end of the meeting the doctor told Segonia that machine guns (the expression of hostility) were important and they both laughed.

In Meeting 143, while Samuels was in a jovial mood, Segonia remarked, "Samuels feels real silly this morning, doesn't he?" Samuels warned the doctor, "Don't trust this thing here," indicating Segonia. Dr. B asked why Samuels did not want him to trust Segonia, and Samuels replied, "I just had a thought. Might not be true." Later when he remarked that Segonia seemed to be feeling better today, the latter did not reply, but Samuels said, "Just because something happened to someone, that's no reason to feel sorry for him; the thing to do is help him."

In Meeting 146, when Dr. B encouraged Segonia to verbalize his feelings, he made some jokingly hostile remarks or pointed his finger like a gun at the doctor. The doctor asked if he were supposed to play dead, and Segonia said, "Uh huh," laughing to himself. This



seemed to upset Murdock very much, and the doctor turned his attention to the latter for the remainder of the meeting. During the next few meetings Segonia seemed extremely disturbed and withdrawn. In Meeting 156, which was mostly silent, Segonia engaged in a great deal of gesturing and pacing. At one point he held up his hand as though he were signaling. The doctor commented that he looked like the Statue of Liberty, Segonia and others enjoying the remark.

By Meeting 159 Sansom had gone into remission and was about to be discharged; Murdock was making his bid for the doctor's attention; Samuels was openly ambivalent and not saying much. Segonia began to take a focal position which lasted a long time, involving him in rivalry with Murdock and a very intense rivalry with Samuels. His extra-group behavior was studied unsuccessfully for indication of other reasons for his increased activity in the group at this time.

Except for some interruptions by Murdock, Segonia dominated Meeting 159. One of the first things he said was that Stieff and Sansom had gone home, inquiring whether the doctor would send him home too. He said that he did not like it at the hospital and that he wanted to go home but not right away. He asked if the doctor were an enemy. He said that not only had the doctor "treasoned" him but that he would like to "treason" the doctor. Dr. B constantly reassured Segonia regarding his doubts, as he vacillated between expressing hostility toward the doctor and sexual ideas about him. Later Segonia said, "I wouldn't double-cross you, you're too noble." His mood shifted rapidly to anger. He called Dr. B a "stinker" and "bad boy," then he giggled coquettishly and shook his finger admonishingly at the doctor—"The test is not worth while. You'll double-cross me anyhow." At one point he threw up his hands and said, "Kaput." At another point he again threw up his hands and said, "I give up."

In Meeting 160 Segonia made several references to Christmas, saying that he had asked his parents to consider taking him home. In Meeting 161 he was very much agitated; he paced back and forth, talked continuously in an aggressive, angry, and anxious way, and swore repeatedly. He said he wanted to kill the doctor because the latter was a traitor. He complained about the doctor's having pulled his tooth. He then asked the doctor to save his life. He accused Samuels, Weems, Murdock, and the doctor of homosexual relations. He said, "Get rid of me, Dr. B. You look like my father. . . . What am I to do? I'm no good. You are. He is, and he is. You're no good, Samuels, own up. . . . They all ganged up on me. They took out three of my teeth," and continued with sexual remarks in regard to his

mother and the doctor. "I give in every time I come here," he cried. "I'm insane, Dr. B. I'm lost. Can you find me, Dr. B? . . . Why did you do it? You are not true, Dr. B." He continued in this vein during the entire hour. His behavior upset Samuels who became furious at different times.

Segonia was in church during Meeting 162. Samuels dominated Meeting 163 with attacks on the doctor; Segonia did not say much, but when he did speak he made backbiting remarks about Samuels. Segonia opened Meeting 164 by attacking Dr. B, saying, "You stink, you're a Jap." At one point he asked if the doctor wanted to fight. Dr. B answered, "No." Segonia said, "I don't want to either," and he walked out of the room. When Dr. B went to see what the patient was doing, he found Segonia sitting in a chair, an attendant trying to force him back into the room. The doctor told the attendant to let the patient go and told Segonia that he didn't have to stay in the room if he didn't want to. Segonia answered, "I'm all right now," and followed the doctor into the room. Later in the meeting Samuels attacked the doctor for not having good sense.

Segonia dominated Meeting 165. He called the doctor "sir" and asked whether the doctor was the prison warden, whether the doctor was married, and if the doctor hated him. When Dr. B said, "No," Segonia replied that he did not hate the doctor either. He invited the doctor to sing with him at Christmas. He asked what hate was (saying that he did not want to destroy things, that he would rather build a home) and later explained that "electric machines are hate, reality is hate." He then asked the doctor, "Do you operate on me? That's not a crazy question, is it? That's not silly." The doctor repeatedly assured him that he would not give him shock treatments, and Segonia went into a tirade against his family and the doctor for putting him in the hospital and then said that he was only kidding. He asked if the doctor liked music, relating him to Samuels, who was a music-arranger. He vacillated between expressing feelings of closeness and fears of rejection. At the end of the hour Segonia lingered to say, "No, it's not worth it—you're treason." Samuels stared at the doctor angrily during a large part of the meeting.

At the beginning of Meeting 166 Segonia said that he was angry with the doctor; told the observer to take over—to ignore the doctor. He said that he wished he could have a pistol the next time he saw the doctor, that he was as tough as the doctor was, and that the doctor had been mean to him. Later in the meeting he said, "I am going down," and slunk to the floor. The doctor stood next to him, urging Segonia to speak, but Segonia got up and walked away. Then he

came back and slunk to the floor at the doctor's feet, saying, "O Dr. B! I'm through, gangster." He did this as the doctor was talking to Zachary, but the doctor made no reply. When Dr. B was talking to other members, Segonia made many gestures to distract the doctor's attention. He threw an ashtray to the doctor, whom he told to catch it. He offered to shake hands and tendered his shoes to the doctor. Other members, especially Samuels, were furious with Segonia, as he accused them—especially Samuels, Murdock, and Weems—of doing things to him. He lingered after the meeting to talk to the doctor about love, hate, and superiority, saying that he was "tough."

At the beginning of Meeting 167 Samuels launched a furious attack against the doctor. Segonia also appeared angry, but during Samuels' attack Segonia sat on the floor against the wall, mumbling and sobbing. The doctor went over to Segonia, saying that Samuels was angry, but adding, "Segonia is very sick; he needs help. He's asking for it. Shouldn't we do something about it?" This made Samuels angrier still, but Segonia stopped mumbling and sobbing momentarily. Then the doctor linked Samuels and Segonia, saying, "I wonder why Dick and Paul are angry?" Samuels replied angrily, "You compare me with any of them? You're in the way." He insisted that he was better than the others. Later Segonia began a whining, whimpering appeal to the doctor, saying, "Give me back my uniform. Give me back my pencil-sharpener," as he lay still on the floor. The doctor said that Segonia was playing the role of the dead hero. Shortly afterward Segonia sat up, saying that the doctor wanted his pistol. He then said that someone had "dissipated" him—had committed fellatio on him.

In Meeting 168 Segonia became openly friendly toward the doctor, appealing to him in a dependent way while frankly expressing his anxiety and anger about Samuels. He asked the doctor to go with him to a place where he could forget his trouble—forget being in a mental hospital. He said that psychiatrists were all right—superior people. Samuels bounced in his seat, his face crimson with rage, as he turned his back on Segonia and the doctor. Segonia laughed and said that Samuels was funny. Samuels stood up, adjusting his trousers furiously. Segonia laughed anxiously and said, "Nothing funny going on here." In Meeting 169 Segonia again showed a dependent, whining attitude toward the doctor and made sly, provocative statements about Samuels, calling him a gangster. Although Samuels arrived at the meeting in a giggling mood, he became upset by Segonia's behavior.

Segonia continued to dominate the group in Meeting 170 but in a firmer and less whining way. He still reached out to Dr. B. After

Samuels had threatened the doctor, the latter said to Segonia, "Dick says I shouldn't go near him." Segonia replied, "Maybe he's dangerous to the cause. Are you?" Segonia quickly noticed that Samuels was absent from Meeting 171, which was held on the day before Christmas. He pointed out that Samuels had gone out that morning and asked in a whining way that he also be given leave to go home for Christmas. The doctor devoted his attention almost entirely to Segonia, whose voice increased gradually in firmness and loudness as the meeting progressed. In addition to talking in his usual style, he expressed the hope that he would grow up to be a big man. When the doctor said that Segonia had a mental illness and had had a nervous breakdown, Segonia replied that it was no disgrace to break down, was it? He talked of Sansom's having gone home, saying, "He ran out on us a few times." Then he laughed. He asked if he could go into the service when he left the hospital. These expressions of optimism seemed to reflect the pleasure he had in talking to the doctor. He said, "The meetings are the best thing that have happened to me." At the end of the meeting he wished the doctor a Merry Christmas and a Happy New Year. Dr. B encouraged him, saying that if he continued improving he would get well soon. This seemed to please Segonia, but his ambivalence was still apparent. He asked if the doctor was for him or against him and if the doctor was tough. He said that he wished he were home so that he would not bother the doctor. He indicated some anxiety about Samuels.

In the first meeting after Christmas Segonia talked and behaved in the same vein. Samuels attended the meeting but during the greater part busily leafed through a magazine, smiling to himself. As Meeting 173 opened Segonia appeared very angry, but as he continued to talk he smiled and laughed. He seemed to act out less and talk more directly about fellatio. The doctor continued to concentrate attention upon him.

In Meeting 174 Segonia again became agitated and whining. Samuels got up from his seat and walked over to the one he occupied when he was friendly. When the doctor noted this, Samuels said, "I should think you'd be ashamed every time you spoke my name." Segonia laughed, sat opposite the doctor, and said, "My psychiatrist—how are you, dear?" Samuels and Segonia thus competed for the doctor through friendliness.

In Meeting 176 Segonia had more open opposition from Samuels and Murdock. He seemed to be able to hold his own against Murdock more easily than against Samuels. Segonia continued to express his ambivalence toward the doctor while trying to keep the latter's in-



terest and attention. At the same time he attacked Samuels, Murdock, and Weems. The doctor began to show more interest in Samuels, paying him more attention than at any time since Segonia had first begun to play a focal role.

In Meeting 177 Segonia whined more than he had for some time. He seemed to have renewed doubt about his relationship with the doctor, asking if psychiatry were bad, saying that the doctor was "through," and had "disperiorated" him. (This might have been related to a developing transference, since he was repeatedly accusing his uncle and father of having done so, and had said that the doctor was like his father.) At the same time, however, he renewed his attacks upon himself, saying that it was really he who had done it and that he was "through." He asked the doctor to "dissipate him, to gangster him," saying that the doctor did not like him. Samuels openly indicated his anger and resentment against the Segonia-dominated meeting. The doctor reassured and encouraged Segonia throughout.

In Meeting 178 the rivalry became more intense. Samuels joined the group in the main rectangle, and Segonia withdrew to a corner by himself. As soon as the doctor entered the room, he was greeted by a stream of self-deprecatory comments from Segonia and by an attack from Samuels so intense that it made everybody jump. Despite this, Segonia kept talking to the doctor. The open rivalry lasted throughout the meeting. The doctor felt that Segonia was more able to defend himself successfully against Samuels, although he continued to support Segonia and focus attention on him. Nobody talked but Samuels and Segonia, who constantly broke in on each other in trying to relate to the doctor. It was the rivalry situation par excellence. Dr. B did not take sides, but acknowledged the patient who was cutting in. This increased the rivalry—helping Samuels to state his objections to the doctor's treatment of other patients, as well as helping Segonia to strengthen his relationship to the doctor as a security measure against Samuels' attacks. For the most part Samuels talked about himself; he never talked directly to Segonia, although he sometimes talked to the doctor on matters raised by Segonia. In contrast, Segonia was intensely concerned about Samuels, perceiving him as a terribly strong and threatening figure. He quixotically asked the doctor if the latter wanted him to fight Samuels. Later he laughingly said that the doctor didn't have a chance against Samuels. On the other hand, he suddenly attacked Samuels verbally and indirectly as he talked to the doctor, saying that Samuels was funny, that he was

not obscene "all the time," and then laughing at Samuels. Some of his remarks sounded as if he were courting Samuels' favor to reduce the threat. Thus, he told the doctor that Samuels was a music-arranger, and that a guard had attacked Samuels unfairly. However, when Samuels did not accept these overtures, Segonia asked in a disgusted tone to go home. Samuels left the meeting still in a rage, as Segonia continued to reach out dependently to the doctor.

In Meeting 179 the patients began attacking each other directly, with extreme hostility but without physical violence, as well as attacking each other through the doctor, as was usual. For example, Samuels turned furiously on Segonia and told him not to say what he had. At this point the rage of both members reached a peak of intensity. They argued back and forth, the threats and accusations flying so rapidly that it was impossible to record all of them. Samuels could hardly contain his rage, slamming his fist on the table, ordering Segonia to keep quiet. Segonia, however, would not be intimidated. He kept talking back to Samuels, his tone firm, his anger expressed directly. He complained of being bothered by Samuels, accused him of fellatio, and told him to "go home," to "get out." This exchange continued for several minutes. Segonia's refusal to be intimidated seemed to have a soothing effect on Samuels, who was quiet for the rest of the meeting. Segonia lorded it over the group for the remainder of the hour. He asked if Samuels were inferior to Caesar. The doctor asked if Segonia were. He replied, "I'm not inferior to my father, sir." Later he said, "I am through, Caesar." Later he said, "I turn on everyone. The hell with the rest. I'm not a hero, sir. I never double-crossed anyone. Have you ever double-crossed me, Dr. B? The patient is always right. The patient comes first." Later he said to the doctor, "You are very noble, sir. O captain, my captain." At another point he got up and said to Samuels, "Hey, Samuels, give me that book. That damn book gangsters me." At the end of the hour Segonia said to the doctor, "I'd like to be a gangster to protect you, sir." Toward the end of the hour Samuels began smiling, apparently enjoying it.

During the next few months the rivalry between Samuels and Segonia continued to be the focal relationship in the group but never again reached the level of intensity of the above meeting. During this time Segonia's behavior on the ward continued to improve by administrative standards. After several months, however, he began to give up his rivalry with Samuels, assuming a more peripheral position in the group. He was subsequently given grounds privileges, following which he seemed to lose interest in group events. He became de-

pressed, confused, and withdrawn during group sessions, began to miss meetings, and once stayed out all night in the woods. In consequence his privileges were revoked several months later.

*Summary.* Segonia became active in this group and challenged the lead patient directly and forcefully after a long period of passive withdrawal. His changed behavior seemed to be related to the strength he derived from the doctor, who encouraged him, and his jealousy of the close relationship between the doctor and the lead patient. It also represented an attempt to overcome his homosexual feelings toward the doctor, which he projected upon the lead patient. He became sufficiently involved to silence the lead patient and was then faced with the problem of homosexual impulses in what was to him an even closer relationship with the doctor (i.e., without the protection that the lead patient afforded him, standing as it were between him and the doctor). In this setting he again withdrew.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

These examples illustrate the potentialities and difficulties specific to group therapy in contrast to individual therapy when the doctor encourages close relationships between himself and the patients as the prerequisite for treatment. This approach created intense rivalry for the doctor's favor and was found to be therapeutically helpful for some patients. The reasons for this and for its failure to help other patients we have not been able to determine.

## CHAPTER XXI

### *Dealing with Prolonged Silences in Schizophrenic Groups\**

---

MANY of our doctors reported that prolonged silences seemed to induce more anxiety among patients than any other group experience, and since the real reasons for them were seldom readily apparent, doctors and patients alike were inclined to project their own interpretations on them.

Each doctor reacted to silences in a characteristic way. Some felt that a prolonged silence indicated hostility and rejection and that their own inability to deal with it was an indication of inadequacy. A doctor who had insisted on composing a group of mute catatonics later described his early reaction as follows: "Up until about the fifth month of therapy my free associations would sound something like this, 'What the hell's the matter with these characters? Don't they know a good thing when they see it?' . . . I was often angry at them and upset. When one did talk to me I had an exhilarated feeling such as a proud father must have when his child first begins to speak." Another doctor reported that he was made extremely anxious by the silence of patients until he realized that it was associated with his father's refusal to speak to him as a punishment for childhood misdemeanors. There is some evidence that his patients had noted the doctor's discomfort and were using this device purposefully, since silent periods occurred in his group more frequently than in most others.

Patients often interpreted the doctor's silence as indicative of a

\*Major contributor: Morris B. Parloff.



lack of interest—particularly in the early meetings of a group in which the doctor was rather inactive. This was well expressed by a patient who complained, "The doctor is unwilling to become involved." Other patients showed anxiety or resentment or both by such remarks as: "In the meeting the doctor should ask questions," "It's the job of the doctor to straighten you out," "The doctor's not talking may cause them (the patients) to become a little more angry. . . . He does not give them anything to go on (i.e., has not assumed his responsibilities)."

The silence of a fellow patient was also anxiety-provoking, apparently because it represented an unknown quantity. Some patients were reluctant to express themselves when others remained silent, as it made them uneasy not to know what others thought about what they said. Some patients thought that silent ones considered themselves superior. One patient who had spoken at great length in the previous meeting turned to a silent patient and remarked, "This person keeps quiet. He must know it all. . . . Must be a pretty smart guy." When the second patient did not answer, the first persisted in his attempt to lead him into a discussion. Finally he asked directly, "What do you think, Mr. Footen?" Footen smiled and muttered, "I'm not running for office."

In an effort to induce mute catatonic patients to speak, three verbal paranoid patients were placed in their group. For a short period these three dominated the meetings. Then they began to ask why the other patients were silent, became increasingly uneasy, and finally fell silent themselves.

#### CIRCUMSTANCES RELATED TO SILENCES

Our study has shown that certain types of behavior on the part of the doctor were regularly followed by silence. An examination of these broad aspects of behavior might be profitable.

1. Inattention or behavior which might be interpreted as lack of interest. A silence might occur if the doctor walked away from a patient who was speaking or responded to a second patient while the first was still speaking; if he repeated a patient's statement incorrectly or showed by his answer that he had missed the point of

what a patient had said. When two or more patients spoke at once and the doctor responded to one, the others stopped talking. On one occasion the doctor entered the room immediately after receiving bad news. Preoccupied with his own thoughts, he remained seated, stared at the floor, frowned, and made only a few overtures to the patients. Of the ninety-nine meetings in which he was observed, this one was by far the most silent.

2. Absence. Following a period during which the doctor had been absent from the group the members tended to be less talkative; even a week-end made the Monday meeting more quiet than on other days. The frequency and length of the silences were diminished when the doctor made a specific point of announcing in advance that he would be absent for a certain period of time.
3. Fear of lack of acceptance. When the doctor was not able to communicate his acceptance to the patients, the latter were extremely reluctant to speak. This was particularly evident in early group meetings, when the doctor was relatively unknown. It was well illustrated by a patient who asked the doctor to prepare the group to withstand the pain of speaking. He suggested that the psychiatrist should administer a drug such as novocaine, "as a dentist does when you have your teeth pulled."

Sometimes patients who had spoken rather freely during one meeting became silent in the next. Several explained that they felt they had talked too much and now wanted others to speak, which suggested that they felt they had exposed themselves in a hostile environment and desired reassurance. When the doctor either directly or indirectly supported certain patients in their attack on another, the latter usually became silent.

4. Fear of speaking for the record. Patients were often deterred from free expression by the presence of the observer, as they questioned the purpose of the latter's notes. Some believed that their release from the hospital depended on these records. Two patients, who were habitually verbal in a group of nine but silent in a group of eighty-seven, explained that they preferred not to speak in the large group, since the doctor had a habit of rephrasing and "distorting" the patients' statements. They feared that what they said would

therefore be inaccurately reported in the record, with the result that the authorities might not find them suitable for release. Others believed that their ideas were being recorded and sold outside the hospital. After pictures were taken of the ward a patient demanded that he be recompensed for his statements, which he believed were being sold to Hollywood. He threatened not to speak, unless he was paid.

5. Preoccupation of patients. After a meeting during which an attempt was made to help a silent patient realize that he was projecting some of his own feelings upon the doctor, the patient remained silent for approximately three days, appearing completely preoccupied with his thoughts. When he spoke again it was to state that he did not think that the doctor has been correct in his analysis. Some patients who appeared to be preoccupied with fantasies remained silent and resented the doctor's efforts to distract them from seemingly pleasant thoughts. One patient sat in his seat, chuckling to himself and gesticulating. He showed annoyance when the doctor attempted to get him to speak and asked not to be disturbed when the doctor persisted.
6. Meaning of speech to the patient. In some instances it was found that silent patients imputed sexual significance to the act of speaking. Oral communication was equated to fellatio or cunnilingus. One patient stated he feared speaking to the doctor lest the latter force him to "swallow his words."

Patients often referred to speaking as if they feared the loss of some of their substance. This inability to give, as symbolized by speaking, was frequently but not always associated with sex. One patient accused the others of being thieves because they listened to him. Another said that he would not speak because "one man's gain was another man's loss."

Silences might thus represent reactions to reality factors or appear in consequence of distorted perceptions or ideas.

#### FACTORS RELATED TO SPEECH

The doctor who found himself confronted by a silent group usually tried to get the patients to talk, but it should be remembered that in

itself speech may have no more value than silence. In our experience three main factors related to patients' speaking appeared to have significance for therapy. The first was the patients' preconceptions of the doctor. In all but one of the original groups studied prolonged silences were invariably followed by requests that the doctor use his authority to obtain their release from the hospital and other favors.

The second factor was the desire of some patients to present themselves in a favorable or superior way to the doctor and the group. They were quick to assume leadership and to comment on other patients' statements. In the first meeting of one group a certain patient asked permission to respond to a question which another had addressed to the doctor. When this was granted, the first patient proceeded to comment derogatively on the remarks of other speakers. A patient who habitually entered the group carrying large textbooks would ostentatiously drop them on the table and then offer comments in regard to them. Soon group members gave evidence of recognizing this patient as an intellectual. Patients who were concerned about establishing themselves unequivocally as virile males would frequently initiate this subject and then challenge group members, doctor, and observer by way of proving their prowess.

The third factor was the tendency of most patients to react to topics of immediate concern to them. It often happened that habitually silent patients would react verbally to opening remarks about which they had strong feelings. The topics might be introduced by either the doctor or a patient, but it was our impression that there was a greater tendency to discuss subjects initiated by patients than subjects suggested by the doctor. The subjects which most commonly stimulated group discussion were: sex, manhood, girl friends, fear, anger, hospitalization, electric shock therapy, insulin shock therapy, and parents. It was noted that although patients usually addressed themselves to the doctor they frequently commented on the remarks of other patients.

### MANEUVERS OF THE DOCTOR

If the doctor can get at the meaning of the group's silence through a review of events just preceding it, he will often find a clue to ways of dealing with it. When the cause of the silence is obscure, the doctor



often has to try one maneuver after another before the patients' resistance can be overcome. Some general attitudes and specific techniques that proved successful in breaking silences are given below:

1. When the doctor showed interest in the group and in each member as an individual, patients were apt to become talkative.
2. Often merely sitting or standing beside a silent patient induced him to speak. In those groups in which the doctor habitually moved about the room it was noted that when he remained near a certain patient for some time the latter might overcome his anxiety and begin to talk to the doctor even without having been addressed.
3. When the doctor welcomed a patient's overtures by indicating his willingness to talk directly to the patient (if only for a short time) the latter usually showed a tendency to become increasingly verbal.
4. Referring to a remark that one patient had made to another during a previous meeting was found to be particularly effective. It showed that the doctor was interested in him and considered his remarks important. Sometimes it proved useful to repeat a remark that a patient had made to the doctor. To a group whose members were complaining of poor treatment in the hospital, the doctor repeated an earlier statement by a silent patient to the effect that he liked the hospital. When one of the other patients asked the silent member to confirm this, he discussed his reactions in some detail. Characteristic expressions were often used in much the same way. In one group a patient always said "wrong direction" when the doctor questioned him; later as the doctor spoke to another patient he looked at the first, who had been silent for some time, and asked, "Still *wrong direction*?" The first patient then began to talk to the doctor.
5. Prompting one patient to comment on the silence of another was most effective when the prompted patient was of the compliant type and when both had openly sought the doctor's attention. Hence this technique was usually not practicable at an early stage of group development when relationships were still tentative.
6. Using certain characteristics of individual patients sometimes proved a successful device. In one group, through the cooperation of one

extremely compliant patient, the doctor was usually able to start an interaction among the other patients.

7. Doctors were frequently successful in ending a prolonged silence by offering tentative formulations based on their analysis of the group situation. The following comments illustrate effective use of this technique: "The group seems angry. Are you angry with me for being late this morning?" or "Cerotti is unusually quiet today. Maybe he's afraid that if he talks Harms will make fun of him again" or "Furnas doesn't like to have anyone say anything uncomplimentary about mother. He seems to be unhappy about what Lanski said yesterday." The patients may have responded to what they believed to be the doctor's interest or criticism.
8. Sometimes a silence could be overcome by a demonstration of willingness on the part of the doctor to talk about himself. On one occasion, when a compliant patient had spoken after a long pause, a second patient had querulously questioned the doctor about his private life. The doctor replied in a straightforward manner, and the three then talked about highly personal matters. On another occasion the doctor relieved the mounting tension by making himself the butt of a joke. After a prolonged silence, accompanied by patients' restless behavior, nervous laughter, and pacing about, the doctor finally interjected, "This reminds me of a game we used to play when we were kids. You know, you sit around and don't say anything and the first one who talks is a monkey. OK, I'm the monkey." Several patients then began to speak to the doctor, and the remainder of the hour was marked by animated and friendly discussion.

Other maneuvers to get discussions under way are illustrated by the three situation analyses given below.

When the doctor had been frustrated in repeated attempts to start a discussion, he sometimes found it effective to place the responsibility on the group. In the following situation, after exhaustive efforts to overcome the group's silence, the doctor finally indicated his disapproval by saying that he left it up to the members to decide how they wanted to spend the group's time.

*Situation Analysis 51***DR. B'S GROUP V-B, Meeting 38**

**PRESENT:** Samuels, Zachary, Sansom, Murdock, and Nellis

**SETTING:** Sansom had taken the focus of the group from time to time and had become a rival of Samuels. He had had Dr. B's support in this contest, but he had shown great reluctance to express himself, while at the same time indicating non-verbally that he was very desirous of the doctor's attention.

During the first part of Meeting 38 Dr. B had unsuccessfully tried sixteen maneuvers to induce the patients to talk. (1) He tried to start a discussion with one patient about being early. (2) He referred to the changed positions of the patients in the group. (3) He discussed the chilly temperature in the room as a metaphor to describe the situation that confronted him. (4) He changed his own position in the group. (5) He used the "weather" and the "seasons" as metaphors for feelings, with the implication that today's meeting need not be like yesterday's, which also had been silent. (6) When Samuels, the lead patient, expressed his resentment and indicated his refusal to talk, or let others talk, by bouncing angrily in his seat, Dr. B referred to the recent "storm," saying that the wind had been "almost a gale." (7) He described the situation in metaphors used by another patient, a rival to the lead patient. (8) He referred to a mute patient who typified the silent group. (9) He remarked that some patients might object to talking because it had a sexual significance for them. (10) When Zachary commented on the weather, Dr. B replied but the patient became silent again. (11) Dr. B mentioned improvement in a certain patient. (12) He remarked that through talking one might get better. (13) He used a parable introducing the idea of Nirvana. (14) He pointed out the relation between the parable and the present situation. (15) He said that he had not tried to achieve Nirvana (implying disapproval) by practicing withdrawal. (16) He asked some members, directly and individually, whether silence made them happy.

**EVENT:** At this point Dr. B stated, "Well, we're spending an hour together. What we do is up to you, whether we work or not. . .," indicating that the silence was the responsibility of the patients. He rose, lit a cigarette, and sat on a window sill in silence. Later he got up from the sill, stood behind Zachary, and then sat between Sansom and Nellis.

**EFFECTS:** Zachary commented that Murdock was quiet, very quiet, and said that he himself was tired of sitting around. Sansom moved to the settee where Dr. B had sat earlier. Then followed a conversa-

tion between Zachary and the doctor in which the latter referred to Sansom's changing seats. Sansom said, "You know how it is, all bunched together strains things." Dr. B asked him if he wanted to relieve some of the tension.

Sansom talked for the remainder of the meeting. He removed his shoe laces and then spoke at length about Benedict Arnold, a court-martial report, separating the accused from the innocent. He said, "As a result of the mission, the general has to drop out of the picture, and let someone else take over, else it's a desperate court-martial." Then he told of taking shorthand in a court-martial. (Sansom's remarks may have been stimulated by his feeling that the others in remaining silent were not doing their duty. In the service the failure of other men to perform their duties had created serious emotional difficulties for him.)

In Situation Analysis 52, the doctor asked the patients to review events in the group that had been emotionally important to them. This encouraged a patient who had just returned from a trial visit to speak.

### *Situation Analysis 52*

#### *DR. B's GROUP V-B, Meeting 86*

PRESENT: Samuels, Stieff, Zachary, Nellis, Sansom, Whittel, and others

SETTING: The lead patient, Samuels, had been very friendly in his attitude toward the doctor. During the last few meetings he had become increasingly jealous of other patients, criticizing them for laziness and non-cooperation. At the moment, however, he seemed to feel sufficiently secure to show acceptance of Stieff, his rival for the attention of the doctor.

Zachary had maintained his constant role of moderator, filling in silences and keeping the affective tone of the meeting on as moderate a level as possible.

Nellis had maintained an attitude of superiority toward the group and tried to relate to the doctor as an equal or favorite son. He, too, tried to keep the conversation on neutral subjects. His relation to the doctor had become ambivalent in recent sessions. He had commented on sports and attitudes of other patients and on his desire for grounds privileges.

Sansom had returned to this group about a month after Dr. B had taken over. Although he was restless, he remained silent for the most part. He appeared very much interested in an exchange between



Samuels and Dr. B. In the last few meetings he had done a great deal of whistling and pacing but had given only single-word replies when addressed by the doctor.

Whittel had remained for the most part on the periphery of the group, replying very laconically when addressed. He spoke clearly and appeared to be one of the better-integrated members of the group. At no time did he talk about himself.

Following a brief exchange between Whittel and Dr. B the group became silent. The doctor asked Sansom, who was smiling and half-reclining on the settee, if he would like to say something, to which the patient replied that he didn't know what to say. Dr. B stated that what was important to Sansom was important to the group and that everyone would like to hear it. The group remained quiet. Samuels cleared his throat and remarked acceptantly that you learn as you progress. Dr. B agreed and offered Samuels a cigarette, which the latter refused. Another silence followed, which Zachary eventually broke by stating that there was a new doctor on the ward, commenting on the large meeting that was being scheduled for Thursday and adding, "Our regular group meeting will be called off again." Another silence followed, during which Samuels moved a flower-pot. Dr. B: "Straightening things out, Francis?" Samuels: "That's what that was for, yes." Another silence and then Dr. B said, "Everybody is pretty quiet this morning." Zachary agreed.

EVENT: Dr. B then suggested, "Maybe we could go over some of the things that have happened here since the meetings started," and Zachary again agreed.

EFFECT: Nellis remarked that he and several others had gone home and Zachary immediately responded by commenting that Nellis had come back. In the exchange that followed, Dr. B defended Nellis against what he felt was intended to be an attack on the part of Zachary. He referred to Nellis as Joe and said that before he left the hospital he would be able to tell the group a few things. Nellis maintained that he still felt he was well enough to go home and explained that he had not been "committed." Then he talked of grounds privileges, while Zachary commented in general terms and Sansom paced. Following this interchange, Dr. B said, "Sansom has been home on a visit and has come back. He has never told us much about it and how he made out."

Samuels attempted to break in by asking on which floor the other meeting would be. Dr. B replied to Samuels but again turned his attention on Sansom, asking, "What were you saying about your temporary visit, Sansom?" During the remainder of this meeting there

were no further silences; Sansom continued to talk at length on sports while Zachary and Nellis broke in, at times simultaneously. At one point Sansom said that he "liked to warm up slow and kick hard," to which Zachary approved, "Good game! Fast game. . . ." At the end of the meeting several patients made favorable comments. Whittel said, "We're improving all the time, but it takes a long time."

In the following situation, the doctor drew silent patients into the group discussion by inducing a responsive patient to speak about his mother, a topic the doctor knew to be emotionally charged for all.

### *Situation Analysis 53*

#### *DR. B's GROUP V-B, Meeting 256*

**PRESENT:** Zachary, Samuels, Worden, Weems, and Seidel (entered the group in Meeting 201)

**SETTING:** For the psychodynamics of Zachary and Samuels, see Situation Analysis 52. The patients were scattered around the room, sitting in silent isolation. Dr. B referred to several patients without getting any response. He questioned Zachary directly, asking him what he was looking for, whom he was looking for. Zachary replied noncommittally, "Something smoother, better. Better things, good sign. . . . It don't make things too clear." He said that he was not looking for anyone. Dr. B referred to a statement Zachary had made in a previous meeting to the effect that the doctor meant nothing to him. Zachary had said at that time that he was involved with his insurance and wanted to get it straightened out, that the doctor was nobody to him directly—"You know, nobody is nobody until you're somebody, get somewhere. . . ." Then Dr. B referred to other patients, with Zachary commenting in turn. Later Zachary talked of getting a job, of getting settled. Dr. B asked what Zachary would do. No other patient participated.

**EVENT:** Dr. B asked Zachary if he would be with his mother when he was on leave and commented that in the past Zachary had had difficulty with her.

**EFFECTS:** Zachary agreed that he wasn't getting along with her too well—he didn't know why. He referred to a disagreement but wouldn't recall the occasion for it. He said that he got upset, but not angry, not out of hand, not to the point of striking her. When the doctor suggested, "Maybe you would have liked to?" the patient denied it. Dr. B said that Zachary probably did get angry at his mother and that he was not the only one here who had. Zachary replied, "Causes a lot

of disturbance." Dr. B: "Causes a lot of disturbance inside." Zachary: "Pretty hard thing to clear up. . . . Takes time." Dr. B: "That's true." Zachary: "Needs figuring out. . . ." Following this Dr. B referred to Worden, who "felt the same way about it" and who "struck at women every time he got a chance." Worden shrugged, stated that he smacked back in self-defense, which was "legal protection." Weems walked between Samuels and Dr. B; Seidel, who had spoken in only two previous meetings and then only on impersonal matters, seemed interested. He raised his head and glanced around as though listening carefully to the conversation. Weems grinned at Dr. B. Samuels mumbled, knelt with his back to the doctor, got up quickly, and sat down. During the remainder of the meeting there were several exchanges, mostly between Dr. B and Samuels, who expressed his hostility openly—saying to the doctor, "I hate the sight of you. I despise you."

In each group the habitual degree of talkativeness may of course be influenced by its composition. Of the groups studied by us the least talkative was the group of catatonic patients referred to at the beginning of this chapter. For almost a year the doctor in charge of this group attempted to break the almost solid wall of silence. He used a great deal of imagination, but each attempt to induce interaction between members failed. After 165 meetings these patients were placed in groups with hebephrenic and paranoid patients and in the course of the next year a few became verbal.

The doctor's attributes are unquestionably of great importance in dealing with silences, but it has been difficult to separate these from other factors. The progress in one group, for instance, seemed to the observers to be directly related to the personality of the doctor. The patients had been diagnosed as catatonic and hebephrenic, but all of them had been mute for a long time before the group started. The group was led by a woman doctor with warm personality who related very directly to the patients as individuals. At this writing the group has been meeting for eight months with verbal interchanges in which the patients have all participated in varying degrees.

The indirect and distorted ways in which psychotic patients communicate make it all the more difficult to deal with them in periods when they do not speak. Even in groups in which considerable rapport

has been established the doctor's problem is intensified by his uncertainty as to the meaning of the non-verbal communications. In such situations it is of paramount importance that he remain patient in his efforts to understand and that he avoid the sense of frustration and anxiety that is likely to follow failure to understand.



## CHAPTER XXII

### *Dealing with Hostility and Sexuality\**

---

IN group therapy no less than in individual therapy hostility and sexuality are feelings commonly expressed in the course of treatment. The doctor's reactions toward them—the amount of anxiety or the acceptance and understanding he experiences when faced with them—as well as his techniques in dealing with them, in large measure may determine the patient's progress.

#### HOSTILITY

Anger may assume various forms and express itself in numerous ways. For many, remaining silent and refusing to respond to questions, statements, or approaches of any kind is frequently used to express resentment. In our groups of schizophrenics, for example, a certain patient maintained a complete silence for many meetings, meanwhile showing his hostility toward the doctor by sitting at a distance, turning his back, pouting, frowning, and at times bouncing in his seat. He even succeeded in imposing silence on the other members of the group at some meetings, and obtained satisfaction from a situation that he felt was frustrating to the doctor. In the catatonic group another patient plainly acted out his hostility toward the doctor. That this feeling was common to most patients in this group is shown by their understanding of the following situation and the subsequent release of their tension.

#### *Situation Analysis 54*

##### DR. A'S GROUP

PRESENT: Bonner, Holston, Olds, Norrison, Leister, Lake, and Keefer

SETTING: The last few group meetings had been very unproductive

\*Major contributors: Albert E. Dreyfus and David Rosenthal.

and apparently ineffectual. During the staff conference prior to this meeting Dr. A stated that in the previous session the group had been as rigid as he had ever seen them. He added that he was planning to give Bonner a good deal of attention in the group and that if this attempt failed, he would turn to Holston in an attempt to obtain some response from Bonner through Holston. At this meeting Dr. A obtained no response from Bonner after talking to him for a long time. Meanwhile all the other group members remained rigid and motionless, except Olds and Norrison, who were moving about on the periphery. Leister lay on a couch, and Lake crouched in a corner.

EVENT: Apparently giving up hope of obtaining any response from Bonner directly, Dr. A left him, walked over to the observer and asked for a cigarette. The observer had none.

EFFECTS: Leister pulled a pack of cigarettes out of his shirt pocket, ostentatiously fondled the pack, took out a cigarette, put it in his mouth, sat up, looked over at the observer and at Dr. A with a sly smile. After a short time his expression changed to puzzlement as he sat up with cigarette still unlit hanging from his lips.

Some of the other patients became restless. Olds shifted his weight from one foot to the other, running his hand through his hair. Norrison moved. Keefer stirred, and there was a definite increase in tension. Suddenly Lake jumped up, pretended to have twisted his ankle, complained about the hospital in a loud voice, offered a cigarette to the doctor, and laughed loudly. He sat down between Holston and Dr. A. After a moment's hesitation, Leister got up and went to Dr. A for a light.

Then all at once Lake, Olds, Holston, and Keefer started to smile and laugh with the doctor. The tension seemed to be released, and for a moment there appeared to be a greater degree of group feeling.

DISCUSSION: It appeared that the patients thought the doctor was frustrated when the observer had no cigarettes. Leister plainly showed that he could give one to the doctor but would not. The anxiety resulting in the group might have been caused by patients' hostility toward the doctor and the guilt felt by all of them for this. A decrease in tension followed Lake's friendly, showy offering of a cigarette and Leister's asking and getting a light from the doctor.

Although verbal attacks on the doctor were sometimes direct and violent to a point just short of physical assault, in most instances the patient's hostility was not expressed directly. One patient denied any hostility but held up his hand in front of his face whenever he made a subtle attack on the doctor. When Dr. A remarked, "If you are going

to talk this way, I can see why you have to put your hand in front of your face," the patient flushed and remained silent for a short period and then took his hand down.

Recognizing hostility when it was indirectly shown and accepting it without anxiety often helped the patient to express it more directly. In the following example from Meeting 146 of Dr. B's Group v-b, a long-silent patient, who had occasionally acted as though he were machine-gunning the room, was able to express his hostility toward the doctor when the latter called attention to the significance of the gesture.

Dr. B: "Segonia is trying to say something. What do you think he's trying to say? Can you guess it?" Segonia turns to Dr. B and points a finger at him as if pointing a gun. Dr. B: "Did you shoot me?" Segonia: "Yeah, once." Dr. B: "A good job. Only took one shot." Segonia agreed. Dr. B: "Guess I'm dead now." Segonia laughed and said he guessed so. Dr. B: "Am I supposed to play dead for the rest of the time now?" Segonia: "Uh huh" (laughing to self). Dr. B: "This is not the first time. Apparently Segonia has in mind to shoot me. He's done that several times. . . . He seems to be getting quite a kick out of shooting me. . . ." Segonia gestured as before. Dr. B: "Bingo. . . . Probably shooting me again. . . ."

For a time Segonia seemed to feel closer to the doctor and then he began again to express hostility, for the most part indirectly. He justified his anger by accusing attendants, nurses, and others of making sexual assaults upon him, showing a close link between hostility and sexuality that may have added to his fear of expression. At this time Segonia was too dependent on Dr. B and too insecure to attack him—he had said previously, "You don't cuss authority." But the impression that a large part of the patient's feeling was actually related to the doctor was corroborated by subsequent episodes, during which he cursed the doctor in no uncertain terms. Later, when Dr. B referred to Segonia's strong feelings, the latter refused to acknowledge these episodes.

Failing to notice the indirect attacks that patients made on one another seemed to aggravate their hostility. For example, in the following situation one patient attacked another by asking a question of the doctor so subtly that the latter did not recognize it as an attack. This infuriated the second patient and led him to believe that the doctor was siding with the attacker.

*Situation Analysis 55*

## DR. B'S GROUP V-B

PRESENT: Samuels, Nellis, Kight, and others

SETTING: The two patients chiefly involved were Samuels and Nellis. At first Samuels had maintained a close relationship with Dr. B, talking about very personal matters in a friendly way. After some weeks he became very hostile, repeatedly accusing the doctor of having engaged in homosexual activities with him. Nellis had maintained throughout a distinctly superior attitude and had sought to be the doctor's favorite on this basis, first challenging Kight and then Samuels. He resented the leadership of Samuels and at times attacked him quite bluntly.

The meeting began with Dr. B's observation that Samuels seemed to be in a happy mood. When Samuels said laughingly, "I'm well," Dr. B replied, "That's good news." Samuels continued to laugh and mumble to himself through the first part of the meeting. At one point there was a brief interchange between Samuels and the doctor in which the patient talked about personal matters, as he often did when he was friendly. A silence followed.

EVENT: Nellis asked Dr. B, "What does homo-pathic mean?" He explained that he had made up this word—*homo* and *pathic* being separate words. Dr. B replied that he had not heard the term before but that it might apply. He asked what kind of patients would be in a *homo-pathic* ward. Nellis said mental patients. A discussion followed in which the doctor explained that homosexuality was merely part of the illness—"Just as you get little bumps on the skin when you get chickenpox."

EFFECTS: Following this conversation, there was a silence during which Samuels muttered something about his home state and a certain mental hospital. The doctor rose and walked over toward Samuels, who said, "Keep walking, Dr. B." When the doctor asked if there was something Samuels wanted to tell him, Samuels replied, "I'm going to kill you in the most cruel way I can think of. You are a criminal." Dr. B asked what his crime was. Samuels, enraged, accused him of stupidity and of having committed fellatio on him. Later two other patients in the group commented that Samuels must be crazy or have "delusions." Samuels said angrily that he was not crazy, called Dr. B a rat, left the room, then returned and asked if the doctor wanted a chair thrown at him. (Samuels had taken Nellis' remark as an attack on himself and had interpreted the doctor's replies as agreeing with the attack, or at least as not coming to his defense.)

Conversely, on occasions when the doctor supported a patient who



had been attacked, the effect of the attack seemed to be completely counteracted.

*Situation Analysis 56*

DR. B'S GROUP V-B

PRESENT: Segonia, Zachary, and others

SETTING: Although at one time withdrawn into an autistic reverie, Segonia had become very active in the past few meetings in his relating to the doctor in a very dependent way. He talked in a whining tone, complaining that others were injuring or "treasoning" him, and constantly appealed to the doctor for comfort, reassurance, and support. He tried to identify himself with the doctor by fantasizing a common origin and could not bear to express any hostility directly to him. Segonia was always careful to explain that Dr. B was not involved in the attacks that were being directed at himself and that the meetings were "good." During this period Dr. B stood by him, encouraging him to express his feelings and to air his complaints. Apparently as a result of this encouragement the patient seemed to become less dependent and frightened and more self-assertive.

Zachary's attitude had been consistently superior. For some months his only role had been that of moderator, filling in silences with impersonal matters or intervening when tension rose or strong feelings were expressed. For the most part he was benevolently tolerant toward other patients. He talked to the doctor readily but had expressed his feelings only twice, and these were negative, as though he had felt a need to reinforce his attitude of non-involvement and denial of his dependency ("You don't mean anything to me").

Immediately before the present situation developed, Segonia, who had been the most verbal member of the group during this meeting, continued to talk at length to the doctor as he stood behind Zachary. Suddenly Zachary told Segonia not to stand behind him—to go over there if he wanted to talk to the doctor. Segonia was crushed by the attack; he cringed at first, then moved away and sat on the arm of a settee, with his back to Zachary and the doctor and his head bent.

EVENTS: Acting as if Zachary were attacking him instead of Segonia, the doctor immediately asked why it annoyed Zachary to have Segonia stand behind him. Zachary was vague and defensive. The doctor then went over to Segonia and reassured him.

EFFECTS: Segonia responded quickly and again began to talk about being compelled by his mother to go to school at an early age. Encouraged by the doctor, he went on to the subject of his failures in

college. Then he spoke plaintively about being yelled at and yelling back—apparently also referring to Zachary's attack on him.

Doctors of course tried to prevent violence from breaking out, if for no other reason than that it aroused such great anxiety in the group that patients were deterred from becoming involved in any relationships. Situation Analysis 42 illustrates how the doctor dealt with the threat of assault by diverting the attention of the first patient to himself. This maneuver warded off a fight and permitted both patients to continue in their former roles. Of the two quarreling patients, the doctor talked exclusively to the one with whom he had the more effective relationship, because he realized that, in this situation, by diminishing the hostility in one patient he would enable the other also to relax.

As already pointed out, the doctor's ability to accept expressions of hostility—whether indirect or direct—proved of paramount importance for therapy. Despite their best efforts, however, doctors sometimes became unconsciously antagonistic. For example, after the meeting described in the following situation analysis, the doctor remarked to the observer that he had not been hostile—although the observer had noted clear evidence to the contrary. As a result of the doctor's counter-hostility the patient became increasingly upset and finally unmanageable.

### *Situation Analysis 57*

#### DR. Q'S GROUP.

PRESENT: Tower and others

SETTING: Tower, the central patient in this situation, had made numerous attempts to obtain the doctor's attention and interest in previous meetings. In Meeting 76 he talked earnestly about a train incident and about his symptoms. He complained that people tried to hit him with their cars. Later he asked the doctor about his girl and advised him to get married. Explaining why he himself had not married, Tower said, "I couldn't teach my children how to read and write." He said that he had had a tough break when he was young—that's why he couldn't read and write. In the following meeting he again gave the doctor friendly advice about studying too much and suggested his going out with women and men. He had refused to come to three meetings prior to this one.

At this meeting the patient expressed his anger to the doctor, saying that he was tired of fooling around, he was ready to crawl into a hole. He was not afraid to die, he was ready—would rather die than mess around like this. If he had done something wrong, why didn't they tell him? He was not afraid of any man. He could fight back. He wanted to get to the bottom of it. His voice was loud and high-pitched. He said he didn't see anything in these group meetings. They didn't do him any good.

**EVENT:** The doctor calmly asked Tower if he were really interested in his own problem or just trying to get back at the group. Did he want to figure it out—want the group to do something about it? "I can't do anything about it unless you want to work with the group. . . . You've been attacking the others so long, they don't want to do anything about it. You've been telling them you're better than anybody else. Ask the group if you are afraid. . . . You're afraid to ask them."

**EFFECTS:** Tower denied that he was afraid. He said, "To hell with the group," refusing to have anything more to do with it. When again accused of being afraid, he challenged anyone in the group who would fight, picked up a flower-pot, and smashed it. Then he threw two more flower-pots and an ash-stand against the wall, smashing them. At this point he was taken away by attendants.

Conversely, the most violent outbursts of rage were handled effectively by a doctor who was not made anxious by them and was not retaliatory. In the following situation, by comfortably accepting the patient's anger and indicating continued desire to help, the doctor brought about a resolution of the anger and relieved the tension of the group.

### *Situation Analysis 58*

#### **DR. B'S GROUP V-B**

**PRESENT:** Samuels, Zachary, and others

**SETTING:** Samuels and Zachary were the central patients in this situation. When the meeting began Samuels angrily ordered the doctor to keep quiet, one observer to write, and another to sit down. He asked what the meetings were for. Dr. B answered, and then there was silence. When the doctor asked if he had done or said anything to make the patient angry, Samuels seemed to be at the exploding point but he kept some degree of control. The doctor suggested that perhaps Samuels felt the doctor was a homosexual (a constant accusation by Samuels in previous meetings). Samuels said that he still felt so; that

the doctor was a rat, and so rotten he couldn't even talk. When Samuels mentioned EST, Dr. B thought he meant that he had had shock therapy recently. Whereupon Samuels said that he was much wiser than the doctor, who was dumb and knew nothing about medicine. Moreover, Samuels said, the hospital wasn't even kept clean. Then he questioned the reason for the presence of the other group members and continued to express his anger explosively about them and the meetings. After a silence, during which the other patients were very still, Samuels said that the doctor was angry.

**EVENT:** Dr. B asked why Samuels wanted him to get angry. Samuels remained silent. Dr. B, smiling and speaking in a quiet tone of voice: "All right, I'm mad. See how mad I am." To which Samuels replied in an even quieter tone: "You don't make sense to me." Dr. B in the same tone: "If it helps for me to get mad, I'm willing to be mad."

**EFFECTS:** The atmosphere of the meeting became much more relaxed. Following another remark by Samuels, Zachary asked, "What's today, Monday?" adding that last week had gone by fast. He then talked about the lounge in the basement of the building and how comfortable it was (i.e., how comfortable the meeting had become). Several patients began to move about, for cigarettes and lights, and Samuels laughed to himself. During the remainder of the meeting Zachary conversed with the doctor. Later, another patient talked to the doctor about his glasses, and Zachary referred to his own nearsightedness, which he said had cleared up when he went into the service. (This may have been an indirect way of saying that he was improving.)

The following situation further illustrates the doctor's technique in handling hostility. In this case also the patient finally quieted down and changed his relationship to the doctor and the group.

### *Situation Analysis 59*

#### **DR. B'S GROUP V-B**

**PRESENT:** Samuels and others

**SETTING:** Samuels, the central patient in this situation, had been extremely labile in his affective expressions and had vacillated between warmly positive and furiously hostile moods in regard to the doctor. The doctor had maintained a consistent relationship with the patient through both moods, encouraging him to express his feelings and supporting him with interest, friendliness, and sympathetic understanding. Samuels, by virtue of the extreme intensity of his affect, the personal nature of his expressions, especially in regard to sexuality



and aggression, and his relationship with the doctor, had for a long time been the focal member of the group.

Following a period of many weeks, during which Samuels threatened, raged, cursed, complained, criticized, or remained silent with his back to Dr. B, he became more friendly again and attributed the difficulty between himself and the doctor to the other members of the group. He made many suggestions as to how the doctor should punish them. Dr. B defended the other patients, their importance, and their right to treatment. Samuels repeated his accusations and his punitive suggestions several times, but Dr. B maintained his own stand on this issue. Samuels became angry again.

Shortly before the present meeting Samuels had cursed and threatened ward personnel and physically assaulted a patient on the ward who was especially manneristic and bizarre. When he entered the meeting room, he immediately began a furious tirade against the doctor. Never before in the group had his fury been so directed, intense, and prolonged. He flushed, screwed up his face, bounced in his chair, moving it menacingly toward the doctor, stood up as if to attack him physically, shook his fist, threatened, cursed, and shouted so loudly that he was heard throughout the building. The group was quiet and tense.

**EVENTS:** The doctor's treatment of the patient during this outburst, which lasted almost the entire hour, could be essentially characterized as follows:

1. He remained remarkably calm. When the patient threatened and menaced, the doctor sat still, nodding reassuringly. His voice was quiet, expressing sympathetic interest. Occasionally he would make a remark such as, "That must have been a painful experience." At one point, although threatened and warned to stay away, he walked close to the patient, maintaining his manner of benign concern.
2. He made no attempt to refute the accusations against him. At times he repeated the accusations, without being defensive about them. He said, for example, "Yesterday I was Thomas Adams. Today I escaped from Alcatraz." After a string of accusations, he said, "Is that bad?" or "I'm being called s. o. b., dirty Jew, and other bad names. I wonder why."
3. He encouraged the patient to give reasons for his hostility and rage and from time to time expressed such understanding as he himself had of them—commenting as follows, "We're seeing someone who is very angry and who is trying to scare us all. . . . I recognize that you hate me and that you're trying to tell me so. But there are other things too." Samuels repeatedly ordered Dr. B to be silent, but the

latter continued toward his goal of encouraging expression and understanding. Persistently, despite Samuels' many and varied efforts to stop him, Dr. B raised this issue again and again.

**EFFECTS:** Samuels unloaded his hostility and rage throughout the hour. Toward the end, he turned away from Dr. B and directed his last sputter at a fellow patient, whom the doctor immediately supported. When Samuels left the meeting, he was calm and had no further explosive episodes for weeks.

In spite of his extreme involvement in his anger, Samuels was able to see and express the relation between his group experiences and his past. He referred to a fellow patient as his brother. He seemed confused about Dr. B. At times he associated the doctor with his father, saying that they had repeatedly committed crimes against him in his pre-hospital life and that they were probably friends. At other times he seemed to see in the doctor a different kind of person, with whom he did not know how to deal. On one occasion he stopped his attack and mumbled to himself, "What the hell's the matter with him?" In a subsequent meeting, he said to the doctor, "You sit there and let people call you something. There must be something wrong with you." At the same time he seemed to realize that the role he had projected upon the doctor did not fit. In the next meeting, he asked, "Are you Thomas Adams? What made me think you were Thomas Adams?" He couldn't decide on the doctor's part in his illness, saying, "I don't know if you had anything to do with it or not."

In the next meeting Samuels asked questions about Dr. B, as if trying to understand him better, and also told more about himself—in effect, broadening the relationship between them but still involving the doctor in his fantasies. He asked, "Do you call yourself Dr. B? Why is it you don't smoke in here? You don't like to say that you didn't stop smoking, is that it? Did you study in Paris? Were you in Russia? Were you on a ship?" He linked his family with the doctor's, saying that both families might have conspired together.

Samuels attempted to reorganize his relationships with the doctor and the group by replacing the doctor as group therapist and demonstrating how he thought the patients should be treated. He quizzed the doctor on a series of medical matters: "I want you to explain anatomy from the knee to the foot. Explain the capillaries in the lungs." When he had shown to his own satisfaction that the doctor could not do these things (the doctor of course refrained from any technical exposition), Samuels said, "I'm taking your place." He then proceeded to quiz two other patients in a hostile, derogatory way: "Are you Blackwood Davis? Do you have false teeth? You can't tell

the truth." This was the first indication that Samuels had given since the early meetings of the group that he was willing to engage in any kind of relationship with other patients.

He subsequently showed increased interest in object relationships. He began to tinker (constructively, according to him) with automobiles on the grounds and talked more about automobile parts and human relationships in terms of automobile mechanics, associating with this several past experiences. He asked questions at great length about the hospital, its lay-out and surrounding areas. Shortly thereafter, he was sent to the occupational therapy division, where he adjusted well.

It was sometimes easier to cope with overt hostility if there was some evidence of positive feeling as well, and this could sometimes be brought out by a simple statement from the doctor. Under such circumstances a marked change was produced in the attitude of the central patient of the last situation analysis.

### *Situation Analysis 60*

#### **DR. B'S GROUP V-B**

**PRESENT:** Samuels, Zachary, and others

**SETTING:** Samuels and Zachary were again the central patients. In the two previous meetings, Samuels had been very friendly to Dr. B, talking at length about his feelings in his symbolic manner. Prior to these meetings he had showed his anger to the doctor either verbally or by a stubborn, aloof silence. In the present meeting Samuels accused Dr. B of being a thief, of being dumb, of preaching Communism, of having a machine hidden. He said that he was wiser than the doctor, that he despised him, that he didn't like his attitude. He said that Dr. B had fooled him, was ugly, couldn't do good, was "the whole trouble around here." His voice was well controlled and soft for the most part. There was some evidence that Samuels' feelings were mixed. He had one of his music scores on his lap and wanted Dr. B to look at it. When the doctor remarked that Samuels had accused him of stealing \$4.00, the patient said, "You may not have taken it with your hands but you preached the idea." He said, "Wrong is wrong and you can't change it, I don't care who you are." When the doctor said that Samuels had shown anger in calling him a homosexual, the patient replied, "That may not be the correct word, but you know what I mean" (again indicating positive feeling).

**EVENTS:** The doctor took advantage of each opportunity to show

friendly understanding. He was oblivious to hostility but sensitive to any evidence of friendliness:

1. He accepted Samuels' hostility and made no attempt to deny his accusations. When Samuels accused him of being a thief, Dr. B questioned, "I've taken something?" When the patient said that the doctor had a machine hidden somewhere, the doctor referred to the machine and wondered about its purpose. When the patient stated that "wrong is wrong," the doctor replied that he was sure Samuels had a particular wrong in mind.
2. He questioned what was behind Samuels' words and encouraged him to express his feelings and find their meaning, with such remarks as: "I imagine something must have happened." "You are feeling differently today from the way you were feeling yesterday. I don't think you really hate me." And later: "You must have some reason for hating me." "It always helps to find the reason for the way we feel about people."
3. He turned his attention to other group members while Samuels was silent. Zachary talked about a pass that "they" had canceled. He said that he had a cousin in Biloxi. He had been there, it was a sociable place; the people were friendly there.
4. At this point the doctor said, "Makes all the difference in the world when people are friendly."

EFFECTS: Samuels then mentioned a fat nurse whom he disliked (instead of the doctor). When Dr. B said that he appreciated Samuels' telling him about it, the patient thanked the doctor and went into a lengthy discussion about the need for making progress each day. He said that he was not rich, that "they" lied about him and might be lying about the doctor too, and that love was stronger than anything on earth. After a pause Samuels rose and gave a music score to the doctor. He said that he wanted to give Dr. B something in return for what he had done, that the doctor should keep the music and not be discouraged, and that the doctor could pay him. He likened the group to a college or temple. His ambivalence remained, however, as he still expressed dislike for the fat nurse. He remarked that some things had not been paid for yet. Throughout this friendly exchange he frowned and spoke through clenched teeth.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

The attitudes and behavior of the doctor toward the extreme hostility of the schizophrenic patient, whether it is acted out, verbalized, or covered by silence, are of the first importance in treatment. If it



arouses more anxiety in himself than he can deal with or if it frightens him and makes him feel inadequate, he is likely to become angry with the patient—with the predicted untherapeutic results. First, the doctor must become aware of the hostility in the patient, even though it be deeply concealed. He must recognize toward whom it is currently directed and let the patient know that he is aware of it. Our experience indicates that an impersonal acceptance of the patient's hostility and a quiet, sympathetic effort to help him to understand the meaning of it, are necessary in helping the patient to work it out. Treatment of many patients consists of innumerable repetitions of this pattern.

### SEXUALITY

It is generally recognized that schizophrenic patients sexualize objects, often concealing the real connotation in metaphorical language. As is apparent in the examples given in the preceding chapters, sexuality pervaded the pathological manifestations in the patients' speech and behavior, although it was not always dealt with as such because it did not seem to be the primary issue involved. In general, sexual feelings and conflicts were not discussed in the groups until fairly late in therapy, when they sometimes became major issues, difficult to deal with, not only because the problems involved were highly technical but also because the nature of the material often caused considerable anxiety in the doctor. When the group was unwilling or unable to discuss sexuality, it was sometimes found that the doctor's anxiety had communicated itself to the patients, who responded by avoiding the subject.

The following two incidents illustrate circumstances under which patients were unable to discuss homosexuality in the group. The doctor made a number of attempts to encourage them to talk about it, but his acceptant words were belied by his voice and gestures. The doctor subsequently told the observer that talking about homosexuality made him acutely uncomfortable—possibly due to his very strict religious training, which taught that homosexuality was a sin.

#### *Illustration from Meetings 10 and 14 of Dr. Y's Group*

Two weeks previously Palmero had become furiously angry with

the doctor in charge of the large group (see Chapter XXIII), when the latter had mentioned homosexuality. The violence of his rage in Meeting 10 of Dr. Y's Group represented a displacement of his hostility against this other doctor. Dr. Y, realizing that Palmero had conflicts over homosexuality, wanted to help him express his feelings on the subject but did not think that an opportunity would present itself before Meeting 14. Then Palmero told of getting into a fight with another patient who "got too close" to him. Dr. Y urged him to elaborate upon this. Palmero seemed uncomfortable and restless and paced the floor. Finally he announced, "That's enough for today." Meanwhile, the group had remained silent, except when Palmero appeared about to drop the subject; then a fellow patient urged him to continue, explaining, "I did a lot of talking yesterday. You do the talking today."

When the doctor was subsequently called out of the room to answer a telephone call, someone asked Palmero if the person with whom he had fought was a "sadist." Palmero smiled and answered, "Naw, . . . we were just playing with each other." It should be noted that whereas the doctor's presence had an inhibiting effect the observer did not act as a deterrent to the patient's open acknowledgment of the homosexual play.

*Illustration from Meetings 48 and 49 of Dr. Y's Group*

In Meeting 48 the lead patient, Lanski, had said, "Some people are attracted to each other regardless of race, color, creed, or sex." Furnas, another patient in the group, appeared disturbed by this statement and denied that there was "such a thing as sex among men." Lanski disagreed, explaining quite specifically, "It could be an act of masturbation." When Lanski asked why people "hold back from sex," Furnas answered that it was because of their "pride, dignity, morals. . . ." "Lanski wants to go to hell," he concluded.

Although the doctor had seemed willing to discuss the subject, he appeared to be tense. He emphasized Furnas' disapproval of Lanski's attitudes and did not support Lanski. Furnas continued to attack Lanski, suggesting that the former felt that the doctor was supporting him.

In Meeting 49, when Dr. Y attempted to continue the discussion of homosexuality, he asked Lanski why the group held back on sex. Lanski responded, "You think it's a dangerous thing. That's your idea." Lanski then stated that he found the subject unpleasant, "Dwelling on matters below the belt is detestable—makes me sick. . . ." He explained that he, like the doctor and observer, came from a good

arouses more anxiety in himself than he can deal with or if it frightens him and makes him feel inadequate, he is likely to become angry with the patient—with the predicted untherapeutic results. First, the doctor must become aware of the hostility in the patient, even though it be deeply concealed. He must recognize toward whom it is currently directed and let the patient know that he is aware of it. Our experience indicates that an impersonal acceptance of the patient's hostility and a quiet, sympathetic effort to help him to understand the meaning of it, are necessary in helping the patient to work it out. Treatment of many patients consists of innumerable repetitions of this pattern.

### SEXUALITY

It is generally recognized that schizophrenic patients sexualize objects, often concealing the real connotation in metaphorical language. As is apparent in the examples given in the preceding chapters, sexuality pervaded the pathological manifestations in the patients' speech and behavior, although it was not always dealt with as such because it did not seem to be the primary issue involved. In general, sexual feelings and conflicts were not discussed in the groups until fairly late in therapy, when they sometimes became major issues, difficult to deal with, not only because the problems involved were highly technical but also because the nature of the material often caused considerable anxiety in the doctor. When the group was unwilling or unable to discuss sexuality, it was sometimes found that the doctor's anxiety had communicated itself to the patients, who responded by avoiding the subject.

The following two incidents illustrate circumstances under which patients were unable to discuss homosexuality in the group. The doctor made a number of attempts to encourage them to talk about it, but his acceptant words were belied by his voice and gestures. The doctor subsequently told the observer that talking about homosexuality made him acutely uncomfortable—possibly due to his very strict religious training, which taught that homosexuality was a sin.

#### *Illustration from Meetings 10 and 14 of Dr. Y's Group*

Two weeks previously Palmero had become furiously angry with

the doctor in charge of the large group (see Chapter xxiii), when the latter had mentioned homosexuality. The violence of his rage in Meeting 10 of Dr. Y's Group represented a displacement of his hostility against this other doctor. Dr. Y, realizing that Palmero had conflicts over homosexuality, wanted to help him express his feelings on the subject but did not think that an opportunity would present itself before Meeting 14. Then Palmero told of getting into a fight with another patient who "got too close" to him. Dr. Y urged him to elaborate upon this. Palmero seemed uncomfortable and restless and paced the floor. Finally he announced, "That's enough for today." Meanwhile, the group had remained silent, except when Palmero appeared about to drop the subject; then a fellow patient urged him to continue, explaining, "I did a lot of talking yesterday. You do the talking today."

When the doctor was subsequently called out of the room to answer a telephone call, someone asked Palmero if the person with whom he had fought was a "sadist." Palmero smiled and answered, "Naw, . . . we were just playing with each other." It should be noted that whereas the doctor's presence had an inhibiting effect the observer did not act as a deterrent to the patient's open acknowledgment of the homosexual play.

*Illustration from Meetings 48 and 49 of Dr. Y's Group*

In Meeting 48 the lead patient, Lanski, had said, "Some people are attracted to each other regardless of race, color, creed, or sex." Furnas, another patient in the group, appeared disturbed by this statement and denied that there was "such a thing as sex among men." Lanski disagreed, explaining quite specifically, "It could be an act of masturbation." When Lanski asked why people "hold back from sex," Furnas answered that it was because of their "pride, dignity, morals. . . ." "Lanski wants to go to hell," he concluded.

Although the doctor had seemed willing to discuss the subject, he appeared to be tense. He emphasized Furnas' disapproval of Lanski's attitudes and did not support Lanski. Furnas continued to attack Lanski, suggesting that the former felt that the doctor was supporting him.

In Meeting 49, when Dr. Y attempted to continue the discussion of homosexuality, he asked Lanski why the group held back on sex. Lanski responded, "You think it's a dangerous thing. That's your idea." Lanski then stated that he found the subject unpleasant, "Dwelling on matters below the belt is detestable—makes me sick. . . ." He explained that he, like the doctor and observer, came from a good



home where the subject was taboo. "It's common decency. Talk about sex will make a person deteriorate in mental factors." The patient refused to discuss the subject further.

In contrast to these illustrations, the following situation analysis shows how acceptance of the patient's sexual feelings and unemotional, uncritical interpretation allowed the patient to express his fears and to talk about his relationship to the doctor in non-sexual as well as in sexual terms.

### *Situation Analysis 61*

#### DR. B'S GROUP V-B

PRESENT: Segonia and others

SETTING: The central patient, Segonia, had only occasionally taken an active part in the meetings of the group and then not for very long. In these instances Dr. B discussed directly what Segonia had to say, but the activity of two more verbal patients generally cut him off. Before the present meeting he had met the doctor in the hall and had asked to be excused. Dr. B joked with him and persuaded him to attend. When he entered the room he remained standing, all the while talking as if to himself. Dr. B asked him why he didn't sit down—didn't he feel conspicuous? Segonia: "No, that's the way I do, keep smiling. Don't feel guilty about anything." Following a short interchange between another patient and Dr. B, Segonia talked about his home town, laughing with shyness and embarrassment. Then he lay down on the floor behind a chair, as if hiding from the doctor, and talked about elimination. He rocked the chair in front of him, rambling on that he didn't have anything, he wanted home, safety, protection, comfort, and so on—to which the doctor responded in a kindly fashion.

EVENT: During a silence Dr. B asked Segonia, "Are you trying to make me see that you feel dirty by lying with your head on the floor that way?" The patient answered, "Yes," and mumbled something about being wounded. Dr. B then asked, "You want me to see how you've been wounded, is that right?"

EFFECTS: Segonia said, "Yes." Loosening his clothes, he pointed to the scars on his groin. Dr. B remarked on Segonia's good development and asked quietly if he wanted to show the doctor his wounds or his genitals. Segonia then talked about operations. Dr. B: "What do you want cut off?" Segonia: "My penis." Sitting on the floor, he first talked about crying and then began to cry. Dr. B: "Go ahead, have a cry. You can do anything here you want." Segonia: "I've done too much of that. As soon as I went upstairs, I felt five hundred threats.

(He became more excited and agitated, his voice louder and hysterical.) When I'm down here I feel so much better." He then expressed his fear of the acute service and added that he wished he "hadn't been made, fabricated." Talking on, he said that the doctor was his father, his god, and his executioner.

The effects on the patient of the doctor's acceptance of sexual talk is further illustrated by another situation.

### *Situation Analysis 62*

#### DR. B'S GROUP V-B

SETTING: The lead patient was extremely labile in his affective expression and vacillated between warmly positive and furiously hostile moods in relation to Dr. B. For some time he had been very friendly and then began to attribute to the doctor sexual desires toward himself. He was completely preoccupied with the delusion that the doctor had practiced fellatio on him when he was helpless. For a long period, he was extremely negative, refusing for the most part to talk to the doctor at all except to accuse or threaten him. But, regardless of the patient's mood the doctor was consistently friendly, sympathetic and as understanding as he could be. He persisted in encouraging the patient to express his real feelings, despite repeated admonitions to keep quiet, and he showed or felt little or no anxiety despite the murderous threats of the patient.

EVENT: In a meeting during which he had made repeated accusations against the doctor, the patient exposed himself, as though in forced submission, and then said resignedly but furiously to the doctor, "There, how do you like it?" The doctor sat still, nodding reassuringly to the patient but saying nothing. The latter stormed out of the room.

EFFECTS: At the next meeting the patient sat in his "positive seat," which he had not occupied for months. He talked for the entire hour, was warm, friendly, and complimentary to the doctor, thanking him repeatedly. He explained that he had been forced to say things that were not true, that he had been wrong in calling the doctor a homosexual, and suggested an alliance between himself and the doctor against the other members of the group, whom he now referred to as the homosexuals.

Sometimes a patient's anxiety over sex could be alleviated by making plain that the doctor understood the universality of the problem. This also relieved the tension of the others. The principle is of course applicable to problems other than sex.

*Situation Analysis 63***DR. M'S GROUP IX**

**PRESENT:** Westerly, Compton, and others

**SETTING:** During previous meetings of the group Westerly had frequently struck himself on the hand or arm, and it had already been brought out, when sex was under discussion, that this gesture was associated with guilt over masturbation. As the doctor and the observer arrived at this meeting, they found Westerly reclining on a settee, his face wrapped tightly in a handkerchief. Later on in the meeting sex was mentioned by Compton, who subsequently said, "Guess I'll have to help myself. Helpless, helpless, helpless, helpless, helpless." In order to encourage him, Dr. M told Compton that he could be a group leader. He then went on to say that the group seemed to be stymied at the moment, that the patients wanted the doctor's leadership but all the leadership in the world wouldn't help them if they couldn't work with the leader on their own problems.

At this point Westerly started to strike himself, as he had done in the past. Dr. M remarked on it. Westerly sat up, turned toward the doctor, then lay down again. Many members smiled or laughed. Westerly, after a short while, began to strike himself again, removing the handkerchief from his face. The doctor mentioned this and said that he was "sorry to see Westerly disturbed again." Westerly—very emotional, his voice husky and low, his face flushed—asked, "What, what?" then struck himself again and again wrapped his face in the handkerchief.

The doctor suggested that talking about sex earlier in the meeting might have upset Westerly as it had before and as it had frequently upset other members of the group. He then suggested that Westerly wanted to break his arm off because of his masturbating. Westerly—very excited, his voice loud, high-pitched, defensive—denied forcefully that he masturbated.

**EVENT:** The doctor said that everyone in the group had masturbated, that every person had masturbated at some time or other. He repeated this idea twice in a reassuring tone.

**EFFECTS:** Westerly quickly quieted down. His voice became subdued and relaxed. He continued to deny that he masturbated, but his tone was affirmative rather than defensive. The doctor followed through by telling Westerly that he would think no less of him if he did say that he masturbated, and then borrowed a cigarette from him. During the rest of the meeting Westerly lay quietly on his settee, apparently comfortable, and he no longer struck himself. The group showed interest

in what had taken place. Compton mumbled something about friendship, and another patient moved closer to the group.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

Masturbation and exposure became a problem in the group only when it was a problem for the doctor. If the doctor was not affected by it, the patients took it for granted as they did on the wards. For example, one patient masturbated openly for almost an entire meeting. Meanwhile, the doctor continued to talk with him and the others on non-sexual matters. Apparently no one was disturbed, and the doctor did not refer to the patient's masturbation until the end of the meeting, when he said casually, "You seem to be enjoying yourself." Patient: "Yeh." The doctor made this comment to be sure that the patient would not feel rejected because of his behavior. In subsequent meetings this patient talked more clearly about himself. He never masturbated again at a meeting.

As far as contact between patient and doctor was concerned, we found that the meaning of the doctor's reaction to the patient depended on the meaning to the patient of his original gesture. For example, shaking hands with a patient is considered correct, and some patients find it reassuring but others interpret it as a sexual invitation. On one occasion a patient approached the doctor as if to shake hands with him and then postured as if inviting a sexual approach. The doctor walked past him without comment. Soon the patient got up and began to talk to the doctor about something else. This illustrates again that it may not be necessary to discuss with a patient each of his sexual gestures.



## CHAPTER XXIII

### *The Large Group\**

---

#### AIMS AND PURPOSES OF THE LARGE GROUP

THE large group was composed of eighty-seven chronic schizophrenics, about three-fourths of whom also attended the small therapy groups described in earlier chapters. About half had been in group treatment for three or four months when the large group was formed. Our aims were to instruct the residents in treatment procedures through observation and discussion; to provide psychotherapy for patients not yet under treatment because of a shortage of doctors; and to take advantage therapeutically of the extraordinarily wide range of personalities brought together on the experimental ward.

In driving toward the therapeutic goal, it was considered necessary for the members of the group to learn ways which would help diminish the anxiety associated with being in the group and at the same time work through their anxieties. To do this the doctor needed to be sufficiently free to accept the full expression of positive and negative feelings by the patients. From past experience he knew that he would be dealing with an undisciplined group, in general resembling a tumultuous mob but to some degree accepting the therapeutic purpose of the group. Maintenance of communication with the most disturbed members was expected to be the single most important factor in establishing the group interaction. Achievement of a process of this sort involves:

1. The doctor must use his leadership to inculcate in the group the preliminary therapeutic goals of purposefulness of discussion and tolerance for deviant individuals. This is achieved by appealing for

\*By Joseph Abrahams, M.D.

support, by giving orders when necessary, by showing equal interest in and understanding of each patient but meanwhile holding the discussion to topics around which the majority can rally.

2. He must open channels of communication by recognizing non-verbal cues (e.g., yawns) and endeavoring to understand their relation to the process going on at that time, by translating schizophrenic language, and by linking together various statements made in the group to bring out their meaning.
3. He must educate the group to focus on interpersonal phenomena (i.e., what people are doing to one another and why) and to examine their own and one another's problems as they are brought out in the meeting.

#### GENERAL DESCRIPTION OF THE LARGE GROUP

The group generally sat in an informal semicircle around the doctor. About eight members gave evidence of attentiveness at any one time, the rest slouching vacuously on or under their chairs, some mumbling to themselves. One patient, eyes tightly shut and fingers in ears, shouted imprecations in a steady stream at current national political figures. Others burst out with hebephrenic laughter from time to time.

Most of the apparently attentive members of the group, who in due time showed evidence of having followed the meetings in rather keen fashion, sat close to the doctor. One of them habitually roved about in the vicinity of the doctor, apparently clowning. A few sat in the rear but spoke in a considerably clearer manner than those up close.

#### *The Patients*

There were several patients who spoke clearly and expressed sentiments which seemed to be shared with other members of the group.

Beaman took the lead in expressing open, violent defiance of the doctor. Prior to the meetings, he habitually stood around the day room, either appearing very dour or addressing the staff in a slavish manner. During the early meetings of the group he threatened the doctor with violence if the latter failed to prove his good will.

Berg rarely spoke but seemed to influence the other members by the intensity of his interest. He seemed to approve of what the doctor

said and to disapprove of what the patients said and did. In the day room he usually spoke to the staff about such things as the weather.

Brink, a somewhat feminine-appearing individual who bitterly accused staff members of spitting things at him, at times talked in a very appealing manner on subjects that he thought might interest them. He soon became a spokesman for the group.

Cursey also seemed to be able to hold the group's attention and to obtain responses from them. He was extremely restless, talking to the staff members and making fun of them by pantomime and sharp neologistic comments. He early made fun of the doctor to the group, and later of the group to the doctor. As a rule he avoided the other patients and often angered them by his pranks, but he sometimes clarified the others' behavior by his words and pantomime.

Gans' words were stilted and repetitious. He often walked around the day room telling the others how well he did on the golf course or in church. When the doctor was in a tight spot in the meeting, Gans would stand up to tell, without feeling, of his visit to the golf course or church, in order to ease the tension. He helped with the ward housekeeping.

Hilman made long-winded speeches about politics throughout the day. During the group meetings he made tangential references to the doctor's and the group's behavior. His voice grew so loud and angry at times that he drowned out all discussion.

Rutherford usually sat in the day room with a vacant smile. He often spoke in the group, gave ambivalent, vague neologistic answers, with occasional clear comments on his and the others' feelings.

Speek was generally vague, disconnected, and neologistic.

These eight patients, while maintaining in some respects an isolated attitude, were nevertheless in active relationship with the group. At times they made plays for its support, although in words and manner they denied their need for response. It was helpful to remember, since the patients' remarks and behavior were often so obscure, that like many people who become uncomfortable in a group they tended to allay their anxiety by clowning, philosophizing and placating, and manipulating others. For example, Brink spoke about himself to those in authority, appeasing or defying them. To achieve his own ends he spoke for the other patients without consulting them and was dictatorial toward them.

In spite of the apparently remote relationships and disjointed com-

munications of the patients described, each in his own way provided a communication potential of remarkable depth and pertinacity. Brink could bring out the defects of the doctor and the other patients, Rutherford both sides of any question, Gans the "good" and hopeful side of things, and Curseý the pathos and humor of a situation. One of the doctor's responsibilities was to make use of these characteristics when they were appropriate. He also tried to explore the appropriateness of whatever came out spontaneously.

Members of the group showed extremely labile and wide changes in their perceptions as the immediate situation changed—for example, from seeing others as crazy or queer to seeing themselves as so. They would refer to a fellow patient as "a nut," "a mechanic," "a fruit," "an aviator," and so forth and claim to be unwilling to have anything to do with "a person like that" and then, on the other hand, would gossip with one another about topics and people related to hospital life. At certain times authority seemed all powerful and extremely malevolent to them, and at others benevolent and idealistic. Each patient tended to see the doctor either as belonging entirely to himself or as nonexistent. He was often believed to communicate by extra-sensory means and to require slavish appeasement or all-out defiance.

The mores of the group reflected profound dissociation within individuals. Each patient at times expressed a rigidly moral code and also a profoundly immoral one with apparent unawareness of the inconsistency when both were shown within a few minutes. At first the patients' behavior was predominantly egocentric and aggressively deviant from conventional patterns. The majority seemed to move away from the few who, like Gans, appeared to act in a socially correct way. Individuals occasionally defended themselves, but the general tendency was to shift responsibility to those in authority.

### THE COURSE OF THERAPY

#### *Introductory Stage: Meetings 1-5*

At the first meeting the doctor introduced himself and the observer, told their purposes in being there, and what would be expected of the patients as members of a therapeutic discussion group. The early meetings were marked by an atmosphere of profound apathy inter-



rupted by persistent verbal attacks on the doctor by two patients and sporadic ones by several others. The group showed flashes of interest when the doctor's sincerity, understanding, and reflective technique were being assailed. Following these attacks problems would sometimes be presented by two of the members. On one occasion Beaman spoke up, "I am married and got into these things. Could a man be helpful to another man if he can? I want to go home. . . . What's their opinion of me? Doctor keeps me here."

A number of patients questioned the doctor's real intent with remarks such as, "Come right out in the open. Why should a policeman take in all troubles of other people and put it all on his own shoulders?" "He is forced to by a bunch of jerks." The majority spoke directly to the doctor—communication between members being limited chiefly to Brink, who spoke in behalf of others, and to Gans, who commented in a detached way on their behavior. Occasionally patients would come out with asides about others, as when Beaman asked, "Who are you—you F.B.I.?" or "What do you call Brink—something sweet or soft? (i.e., homosexual)."

There was a brief discussion of the hospital as a reformatory, with four members participating, and then a quick switch to the subject of a train ride and a woman's death. This hint of punishment and having been taken for a ride by a woman who deserved death came up repeatedly and more clearly later.

During this introductory stage the doctor replied to patients by reflecting back a "translated" condensation of their material, paraphrasing and referring questions to the group in order to train the patients in the associative process. He also made connections between the remarks of various individuals based on his associations to their statements.

As a part of the education of the group he showed several film strips, encouraging the patients to associate to the dynamic parent-child situations represented in order to figure out their meaning. The group associated freely to the pictures, at first jokingly (calling the characters by names in newspaper cartoons) and later with open hostility. This culminated in a hostile statement by Gans, who was usually compliant, in reference to a picture of a boy looking into a mirror, "I get mad

when I shave. I get mad when I have to pay my compensation for shaving and haircuts."

By Meeting 5 changes had begun to appear, in that the rivals for the doctor's attention took open cognizance of one another, other members of the group besides the original spokesmen participated, and the word "we" came into usage.

### *Later Stages: Meetings 8-62*

*Expression of ambivalence about the doctor: Meetings 8-11.* By Meeting 8 Brink, Beaman, and Hilman had made overtures to the group as a whole, two asking for support, the third asking members to express their view of his character. The rivalry situation became more overt, and the ways of discussing problems moved further toward conventional patterns. Patients touched briefly on a common problem, the "secret" which had brought them to the hospital, then went on to the purpose of the group and daily life in the hospital.

Hilman: "What is wrong with a party to hold a secret out on a person? It is best to leave secret out in the air. Smells fresher than stale. Holding back causes big disturbance in government."

Doctor: "What does the group think about this secret? How about the secret right here in the group?"

Unidentified speaker: "What is the secret?"

Hilman: "That sweeping-the-floor people would not tell you when you came here, and also they did not tell you how long you were going to stay here. Did they tell you they were going to give you electric shock treatment and that it was for the outstanding mind? No, they didn't tell you."

Beaman: "What is the secret for us to see—numbers. I am not going to go out the way they brought me here." Walks out of the room.

Doctor: "What does the group think of what has been said here?"

Hilman: "What is the purpose of this big session once a week? Is it going to do me any good? Is it doing me good once a week?"

Doctor: "Let's ask the group. What does it do for Mr. Hilman?"

Rutherford: "Gives him help."

Hilman: "What I mean, do I get any benefit from it? . . . Would the President be doing any injustice? . . . It's what the group feels about me. Maybe I am rough and careless. I am not careless and rough. Nurses and attendants think I am terrible. They do not know." He then went on to speak of the "outstanding chicken coop."

Beaman: "We have to trust God."

The ambivalence toward the doctor in Meeting 8 was followed by an outbreak of intra-group hostility in Meeting 9. Rutherford asked, "Are they as crazy as they look, or are they just putting on?" Hilman announced, "I am locked up to keep you guys from getting jobs in the White House." Various members were described as unable to use their heads, sick, crazy, killers, or snakes, as having lost their personality through hospitalization or as "injurious in the multiple." Hilman shouted that he did not want to be like the others in the hospital or participate in the group—"They put Henry Ford in a casket. Now all the Fords are dead. Curse on people locked up—don't want to fall into anything, stay out of anything." Following an implication by the doctor, several members of the group took the position that Hilman was trying to steam-roller the group. Whereupon Hilman threatened the doctor and the group with: "A chair comes up in face making it yellow, pink, and purple." Kight, Footer, and Rutherford sneered at Hilman as a "fourth wire radio," and a "giver-off of heat," commenting on his disillusionment, suspicion, and hatred.

In Meeting 10 the group discussed whether the doctor was benevolent or malevolent—ending with some agreement in favor of talking with the doctor instead of assaulting him. Beaman, Juelks, and Kroll each in turn threatened the doctor. Kight, Hilman, Rutherford, Sherry, and Holman defended the doctor verbally, although with relative feebleness.

In Meeting 11, on the doctor's suggestion, a chairman, Sheller, was put in office by a desultory vote. Although he had volunteered, the chairman showed a deep ambivalence about his position and the group barely tolerated him. When the group turned against Juelks, who had threatened the doctor and the other patients in a bullying fashion, the chairman stated, "You're out of order. That's what happens to constructive ideas." Finally, the group accepted a measure of control of its members.

*Group-centered discussions with thematic continuity: Meetings 12-14.* By Meeting 12 group control through a chairman had proved unfeasible, but the mores of group discussion had begun to emerge. Members showed cautious initiative in speaking of personal problems. The theme of sabotage was brought up by Gans.

Gans: "I am a sabotaged patient. I want to know how the group feels about being sabotaged."

Brink: "I will give you a good example of my life. . . . I was borned of foreign parents. When I joined the service, I went to radio school.

I felt like a Nazi. I liked the Nazi song, 'Lili Marlene.' Couldn't tell anyone because it was confidential. Two M.P.'s brought me to a hospital. . . . Mr. X used to chase me and shake a cane at me. . . . Prove to me my name is Brink. How am I going to prove my name? My mother's is a different name. Prove to me. . . ."

Hilman gave a long harangue on two cows giving brown milk and a third cow losing delivery.

Gans: "I think Brink is sabotaged."

Brink: "I wouldn't say I was sabotaged. I'll make some money while I am doing it."

Gans: "I want to know how the group feels. The reason I want to know how the group feels is because I am weaker."

Meeting 13 saw Gans and Cursey acting as hosts by serving the refreshments. The discussion was generalized on feeling low down and disillusioned. There were a number of abortive but sharp interchanges, such as the one between Brink, Kight, and Rutherford about Gans.

Gans: "I have twenty-four hours to polish (the floors)."

Rutherford: "You're not strong. You don't have control over my fee and myself."

Brink: "In other words, the spirit Jesus Christ takes orders from God the Father."

Rutherford: "These pictures are more alive than you think."

Kight: "It doesn't do any good to feel low down."

Brink: "What do you have—yellow fever?"

Rutherford: "You feel so low, you act. . . ."

Brink: "When the war started, I wasn't a man yet, just eighteen years old. You're a man at twenty-one. When you were over there it didn't make any difference. . . . What are you creating up there?"

Kroll: "Yellow fever."

Kight (to the doctor): "What I can't figure out is why we are always innocent and you say we are guilty."

Gans: "I don't want to take any more medicine."

Rutherford: "They say . . . if you're in a hospital, you might as well pass the medicine around."

In Meeting 14, this sort of discussion continued, with pairing of members.

Brink: "You looked up, Rutherford? . . . Not free yet; people keep closing you up. . . ."

Rutherford: "You know where you get the idea of beating a man's mind?"

Brink: "Got it from a man. . . ."



*Group-centered discussions with thematic continuity and personalization of themes: Meetings 15-19.* The patients gradually began to apply to themselves what others were saying and to associate to others' personal material. As the themes developed feelings related to dominance were transferred to the doctor and other members of the group, and sexual connotations were given to words and acts.

In Meeting 15 two patients participated in a discussion started by Cursey, who suggested that differences be merged and that assault and derogation be stopped in the group. This was followed by an assault on Berg by Simmers, a speech by Samuels on the necessity of reproducing life and of reaching thought by reason, and a harangue by Hilman on dividing articles in the "right progressive way."

This vague ambivalence on the issue of taking stands and resolving differences was continued by Simmers, who shouted belligerently, and Gans, who began by asserting, "I am a member of the American Legion and a citizen of the United States, and this gives me the privilege to do anything I want."

This brought out a statement by Stunpf, a previously mute patient, who haltingly told the group that he had problems and needed to consult someone to solve them—"You must take into consideration it is your life." (His problems were later found to be about homosexual involvement.) This brought on a general discussion of the responsibility of the individual and the doctor and of the individual and self-help.

The sessions gained increasing coherence and continuity. In Meeting 16 the theme of homosexuality, which had been vaguely broached by Stunpf at the last session, was discussed by Footer, Samuels, and Cursey, the latter asking, "Doctor, if there are any queers in this group, can we talk to them?" Stunpf was silent during the discussion.

In Meeting 17 the group spoke about relationships with fathers and others in authority. Footer was hesitant and ambivalent about the doctor's intentions, commenting, "People are not interested but assume responsibility. . . . It's a psychological divorce. I can't convince myself there's a way out." Rutherford stated, "John (Footer) says believing is seeing. . . ." Brink asked bitterly, "What do you want from these guys? Come here and stay, plenty of room to play with yourself—plenty of odd beds. You can have mine—I'll sleep on the floor." Sheller: "It took 5,000 years to get well last time, seemed like a year and a day." Footer went on to tell of his experience in the hospital, of being shoved around. When the doctor asked what the

group might have against Footer that he doesn't have against himself, Samuels talked about a cactus.

In contrast, at Meeting 17 Hilman assumed a confessional attitude, also talking about the isolated position he held in the group: "I am crazy all the way through. I've had brains in my shoes. . . . Have to talk about my troubles that happened twelve years ago. Now I have to confess. I might be in the way of somebody's mind, the way of somebody else's trouble to get out." When Footer interrupted to mention an isolation room on another ward, and the group laughed, Hilman answered, "I know how to take a crack on the jaw and others can't. . . . I can't be on a party. I am not a patient to be with then. I'm crazy. I am not wanted." Footer: "You need some fresh ground." Hilman: "Get the hell out of here. . . . Lots of people laugh at times. I laugh aloud at people. I walk a lot. . . . Sometimes I feel insane. I'm not getting out of here. So long, Josephine." Talbot and Rutherford were agitated as Hilman brought out his feelings and other patients heckled him in a kidding manner.

In Meeting 19 the group followed the theme of despondency about past failures, the future, marriage, and manhood. Rutherford and Brink, in particular, talked of the impediments to getting their manhood back, coupling this with problems of submission to the doctor and electric shock treatment. Rutherford stated, "Man without house to go to. . . . You're afraid and I'm shaking." Talbot spoke resentfully of electric shock treatment and fighting the doctor, wondering why all this attention should be his and ending up with the comment, "If they'd listen to the Ten Commandments, they'd get their red corpuscles back, by spontaneous combustion." Gans replied, "We should drink a lot of milk to get red corpuscles." Rutherford asked, "How can you be a woman and not be a man at the same time?" Talbot followed with, "You're using the same sort of incomplete expression I use. You're holding back a bit."

Rutherford: "A lot. Wish I could hold back more. . . . Milk running in with corpuscles and eating the heart up. . . . Penis is something else which makes you hungry for milk. That's not in the mind. Mind and body are two different things. When I came in here, I was mentally unbalanced. I said, 'When I get out of here I'm gonna be in good shape or know the reason why.'"

Talbot: "The trouble about this place is. . . . I never think I'll have that fear again. I'll never let my mind feel that trouble again."

Rutherford: "If they didn't open their mouths, they wouldn't get in trouble again."

Cursey: "Do you have to wear six-shooters, in our belts to convince the doctors we don't want electric shock here?"

*Group-centered discussions and thematic continuity with increasingly direct expression of feelings, including ambivalence toward one another: Meetings 20-62.* The patients gradually showed freer and more affective association with issues and material brought out in the meetings. In this process there developed marked but controlled intra-group hostilities. Individuals became increasingly integrated in the group as they found fairly consistent and secure places in the discussion, and more conventional modes of verbalization were used. Leaders developed among the patients as problems were worked through. These trends continued up to the termination of the therapy.

Meeting 20 was marked by an interchange between Footer and Rutherford, with Rutherford bringing out in a semi-argumentative way Footer's problems in regard to his relationship with his wife. There followed a general discussion of women as promiscuous and untrustworthy, with Samuels violently accusing the doctor of being evil because he permitted ideas of that sort to be expressed in the group. Brink, Talbot, and Gans discussed religion and psychiatry in terms hostile to both. Footer advanced the necessity for a good sexual adjustment and dared anyone to make a pass at him, but spoke of the futility of being anything but a part of a woman. This discussion was carried on mainly by the group, with the doctor playing an evocative role and several patients taking fairly well-defined positions: Rutherford that of a provocative agent, Footer that of a confused, searching individual, Samuels that of a rigid moralist, and Brink and Hilman as defendants of their rights. The clarification of Footer's muddled thinking about Samuels' hostile projection upon the doctor was remarkable. In this meeting it would seem that (1) division of the group into sides on Footer's personal problem led to (2) a generalized discussion, following which (3) Samuels projected his feelings upon the doctor and (4) Footer defended the doctor and in so doing (5) clarified his own problem.

In the next eight meetings an intense struggle went on between a group of patients who stood up for practical solutions of personal problems and a group (called Jesus Christs by their opponents) who increasingly expressed resentment against "controlling" authority, "negativism," and the satisfaction that their families felt with conventional ways of life. Previously incoherent members who had only

acted out their feelings (slapping themselves and making hostile gestures) spoke clearly for the first time.

Relationships with authority were apparently worked through to the extent that, at Meeting 30, Rutherford announced that he had been elected chairman before the session began. (The doctor had earlier encouraged the group to elect a chairman.) Brink complained about Rutherford's chairmanship, but not about him. Rutherford replied that, although Brink was also probably speaking for others in the group, he had just made his own side stronger. After describing his fears in school Brink said, "A baby got sick because he was told off by someone in middle age—that's what happened to me. Do I have to take in what the doctor says?" Rutherford answered, "When you talk about doctors, I see red." He later referred to Brink's "biggest fear of woman turning into man and man into woman." Rutherford remained as chairman, and on his own initiative continued talking with Brink on the latter's loneliness as a child and his difficulty in expressing emotion. The previously dissident members, such as Beaman and Hilman, were generally quiet. In the next meeting Rutherford decided to act as the doctor's assistant rather than as chairman. The group discussed "religion versus cancerous acts involving the mouth," and "marriage out of wedlock in one's father's path"; also the relation of the patient to the hospital, and the possibilities of acceptance by society.

In Meeting 32 a number of patients, principally Rutherford and Brink, talked of themselves as "murder rats." Letting go the self all at once, they said, "might hurt somebody." However Tiller spoke of the group as a "lonely hearts club" and Samuels identified it with the Armed Forces, adding that the floor should be scrubbed with a brush before it was waxed.

In Meeting 33, after Rutherford, Brink, and Footer had discussed death and their own desperation, Sweet admitted that maybe he hadn't cleaned the floor right the other day and spoke of his suspicions of foreigners as enemies. Brink brought out the note of forgiveness for one's misdoings through suffering. Other members then spoke of woman as deserving to be punished because she bore men.

Meeting 34 was in the nature of a bull session on leaving the hospital "jail." Samuels, Lobas, Sheller, Brink, Rutherford, and others were active in their usual roles. Sheller talked about his two-week visit home, saying that it had taken him two weeks to get back to reality and that just as he was getting there he had to return to the hospital —"My trouble is I have a few things that I had to get mended up



inside of me, some bones. Some of us are too particular. Should have one meeting like this every day."

In Meeting 35 the theme of how to clean up one's thoughts and feelings was discussed, with Samuels assuming the dominant moralistic role. Other topics discussed were difficulties in trusting others, memories of belonging to life outside the hospital, sexuality as akin to dirt, the problems of a member of a minority group in a hostile environment, and sleep as an escape.

On arrival at Meeting 36 the doctor had turned off the radio, which was broadcasting the World Series, and the group divided on attacking and defending him. The attack was begun by Samuels, who asked the doctor what was under the crust of the earth. The doctor asked the group for ideas, and Footer, Rutherford, and Sheller came out with gradually clearer data on the anger beneath their crust, their ambivalence about submission to authoritarian domination and homosexual advances. Sweet and Parham, the latter a patient who was usually incoherent, came out with statements that there was "nothing on either side" for them. Sweet brought out his ambivalence in serving two masters, loving one and despising the other. Sheller made a point about an eruption caused by Pluto through Mars and about his need for independence and his relative powerlessness. Beaman challenged the doctor in his wild, almost assaultive way. Hilman spoke of the need for accord in the group. The meeting was remarkable for the consistency and wide range of expression in the discussion of submission, and the group did not fragment under the impact of the anxieties over submission and homosexuality.

In Meeting 38 there were a number of trends, converging and diverging. Some of the patients were vindictive toward the doctor as a symbol of authority, while others, still bitter but noting the folly of their past ways, defended him—"When I have a child, I will beat it to put better sense and attitude in its head." They discussed the feeling of being controlled by the hospital after leaving it. Their feelings of low self-esteem and lack of virility were related to submissiveness to authority and were expressed by describing members of the group as tending "to patch things up rather than to run away" and as not being "real, unresistive homosexuals," who need "to gang up like wolf packs." Cursey and Dobbs reached out to the doctor in clearly worded communication, while Brink gave vent to his jealous rages.

Cursey was described in the next session as a "flat piece of metal," as imitative, stupid, and misusing his body. In reference to him Footer mentioned "the heel which is in ourselves." The question of repairing

one's manhood was brought up again. As usual, Sheller resolved to ignore his doubts in his manhood through faith in the doctor. Brink attacked the doctor as not feeding him the right ideas. The others were ambivalent about their acceptance of their own "weaknesses" toward homosexuality. There was a rising note of hopefulness in the discussion.

In Meeting 41 the members lined up on the issue of submission, with a great many shouted accusations and counter-accusations about who should take the initiative in changing—the doctor and society or the patient. Brink was furious at the doctor for his lack of interest and linked his protest with the difficulty he had had with his parents. Lobas compared the group to pieces of wood hauled on a train. Sheller stated that the members were prisoners of themselves.

Meetings 42 and 43 were extremely active on the problem of the danger (likened to atomic explosion) of bringing out the full conflict of ideas present in the group. Brink expressed intense resentment against the doctor for being like his father. The subject of fellatio was hinted at. The subject of children as their own parents, brought up previously by Brink, was further discussed by Footer, as well as homosexuality as a sickness.

In Meeting 46 a patient described the problem of holding one's own with a woman as submissively "tasting" her and swallowing words. He added, "I spit out words to people until I get one who can swallow it. . . . But I don't want to have a stubborn streak like I was born with. . . ."

The group's resentment against being forced to passivity by a woman was further expressed by Footer and Brink in Meeting 47. Barkert described the group's movement toward re-examination of their attitudes in regard to their parents as "going to paradise in a pair of balloons."

In Meeting 48 Stunpf, derided openly by the group, protested his willingness to be a woman. Brink brought out his resentment against having been told how to eat, dress, and play by a woman.

In Meetings 49-53 various patients, projecting upon the doctor, expressed bitterness toward him "as a woman" and accused him of lack of initiative in helping them and of dominating the group so that it would go the way he wanted it to. Stunpf became clearer in expressing his delusion that the doctor was compelling him to submit homosexually to the others. Some were protective of the doctor when Stunpf, in protest, threw a chair toward him.

Cursey: "They're trying to kill one another and the man of the house wants to stop it."

Stunpf: "I have no desire to be turned into a complete sucker."

Sweet: "It seems like we're all bicycle riders, riding on the high wire, we're all falling off the wire."

Cursey: "Have you ever tried looking at your knees (prayer)? I think that would help your discussion. . . ."

Sweet: "As I see it, it's sort of like the Christ Child was born in the manger. A child doesn't grow up overnight. It takes him time. It takes a grown person with a lot of endurance and strength before they can ride a bicycle over a wire without falling off."

In Meetings 54-58 the patients discussed with increasing emotion their feelings of guilt and of deserving death and also their need to repress woman-like feelings. The latter was expressed by Talbot, who said, "I feel like a woman, and need protection." There was a great deal of talk of counterfeiting and of being forced to follow the group and violent denial of any meaning to the discussions. Stunpf was a focal member in these discussions, representing himself to the group as a homosexual but expressing resentment of advances.

In Meeting 60 there were definite signs of rapprochement between group members who had formerly been in conflict. Lobas befriended Stunpf, accepting his rather appealing social advances. Stunpf stated, "I am not afraid of reality, but reality is afraid of me." Talbot stated, "Decisions are hard to make . . . and . . . if they won't fit in the chairs, they'll never be cured. . . ."

In Meetings 61 and 62 patients spoke of their need for courage and referred to the meetings as the "beginning of time." The subject of manhood was discussed with less violent disturbances than in former meetings. Lobas said, "These men that call themselves men. . . . I don't want to have anything to do with aviators. The group meetings know too much." Stunpf stated, "I'm under a strain. The fact remains that I do actually have the possibility to be a child," and went on to describe the use of intelligence in getting "out of this mess." The patients discussed whether a year in France would make men of them, the emptiness of their lives at 8 p.m. (when they go to bed), and how one can deliberately make another man ruin his life.

The discussion swung, in the next meetings, to the value of recreational activities for bringing Stunpf "to re-establish himself and build himself to a state of recovery." Stunpf called for more active leadership. With his fingers out of his ears, Hilman said that the "parade" the group was in was not the "music" for him. The group discussed the "big improvement" in handling patients during the past year and a half. Stunpf spoke of involvement and his "attempt to confess," adding, "Sometimes you can jump overboard and end it all. Tie an

anvil around your neck. The only thing is, you might not accomplish your purpose." Rutherford asked for some energy to enable him to snap back when he felt low—"When a man has a quick snapback . . . , can move it. Shows he's living, and nobody else can control his mind." Dwight stated to Stunpf that he shouldn't worry about hurting others' feelings. He compared the process of recovery to getting out of a barbed-wire entanglement and suggested choosing one's associations so as to not have to fight them.

In the last meeting Stunpf's tendency to antagonize other members of the group brought out an intense reaction from Lanski, who seemed to be in a whimpering, mourning state over the doctor's leaving the group. When Stunpf got physically closer to the doctor, Lanski cried out, "Sit down, queer. Sit down, before I kick your ass." Stunpf then talked of solitary golf as not helping him and was encouraged by Dwight to play in the orchestra. Stunpf stated that his trumpet-playing was very helpful—"I help others by my playing. . . . Music is the only thing ever. . . . But when I speak to others, I always get into trouble." He compared himself with a man who can't walk and plays marbles and blames his family. Lanski whimpered at the doctor's feet in an infantile manner. Stunpf stated, "I play with a group, but what comes out of my horn is mine. It's my own air." Dobbs said that he couldn't find a team to get one. Dwight, commenting on Lanski's behavior in relation to Stunpf, stated that a moral coward has to have others do what he wants them to do. When they don't, he calls them "animal cowards." Hampten shook hands with the doctor and announced, "I'm a man." Stunpf stated, "The other fellow's mistakes are just an inadequate form of expression."

The group had arrived at the stage in its development where the members could discuss the problems they were anxious about with some expectation of alleviation, if only in the distant future. They felt secure enough to come out with fairly clear expression of emotional content, ranging from highly intellectual concepts to direct expression of low self-esteem, homosexuality, submission and dominance, rebellion and murderous hostility associated with present and past relationships. For example, Stunpf was brought face to face with his unconscious tendency to antagonize people through his "innocent" but provocative homosexual tendencies. From the way he spoke these tendencies appeared to be sexualized infantile longings for tenderness with the expectation of rebuffs. He encountered hostility at first, but as the group gradually became more acceptant, he received some guidance away from "playing with marbles." In learning to deal with him, the others began to learn to deal with their own feelings, their



fear of being hurt if they accepted help, and also their violent and desperate hostility toward the projected image of a rejecter.

### REACTIONS OF INDIVIDUAL PATIENTS TO THE GROUP PROCESS

As indicated in the above description of the development of the large group, Brink was a leader in the sense that he expressed a number of the dominant trends of the group.

From the first he verbalized more freely than the others. He vigorously attacked the doctor as hypocritical and malevolent—often with wild expression and blanched face. He spoke without reference to others who were shouting at the time, ignoring and being ignored by them. In Meeting 4 he began speaking for the group without consulting the others. From his own point of view he was the exclusive spokesman. In this meeting he also initiated his constant theme of "Why should I take the language and words you spit out at me?" After particularly prolonged harangues at the doctor (in which the doctor verbally "stayed" with the patient, exchanging statement for statement, chiefly by reflective technique), Brink would sit down somewhat smugly, smile, and refer in a derogatory way to the group process. In the eighth meeting, after his preliminary bombardment of the doctor, he referred some of his preoccupations to the group—his dislike of his name, ancestry, relatives, and his relation with his father—calling it all "psychological dirt." The group was relatively unresponsive. In the next meeting he competed with Footer for attention; at the end he reached out to the doctor by suggesting that the latter come and stay with the patients.

A few meetings later, after Hilman, a particularly obstreperous, domineering member, had confessed to being "rough," Brink talked of a peace treaty but appeared very much concerned with the problem of "swallowing" what was "spit out" and denied the possibility of learning from others. In the next meeting he spoke of his equality with the group and doctor, and the desirability of higher regard for one another. He kidded Gans, a rigid, very religious patient, on the need for his priest to be a psychiatrist.

In Meeting 13 he discussed the meaning of speech further—"If I learned to talk the way others do, would I feel guilty? Can't talk about sex here." He interchanged opinions with Rutherford on "coming" and love. He called the doctor an "atomic doodler who doesn't know what he's doing," when the latter attempted to guide him to express

his underlying feelings. In the discussion which followed on the need for a commanding officer, Brink reminisced on his destructiveness in childhood and his subsequent turning to constructive pursuits because of guilt. He joined in a discussion with Rutherford and Footer on dreaming of women—"Maybe the war caused that."

In Meeting 14 he talked about understanding and misunderstanding with Rutherford, holding that it was the other person's feelings that were responsible for his troubles. In Meeting 15 he sided with patients who were attacking the doctor with demands to be sent home or open threats. At one point he turned on the doctor with blanched, angry face, in active sympathy with Basmit who shouted, "If they want dog-eat-dog, that is what they'll get."

In Meeting 16, in response to the doctor's challenge to the group, Brink talked about the inconsistencies and cultural inadequacies of his parents. In the next three meetings, he engaged in an intense verbal exchange with the doctor, alternately fuming about his family's lack of understanding and projecting upon the doctor malevolence, hypocrisy, and images of spitting. When the doctor mentioned Brink's guardedness about taking things in, Brink spoke of his resentment against his parents and the possibility of having been born with resentment. Various members expressed resentment against Brink's dominance. In the next meeting Brink made a particularly desperate attack on the doctor.

In the next meeting, when Brink talked about his preoccupation with his "sissy" status in childhood and his chastisement by his father, he was openly supported by Rutherford who had been elected chairman. Subsequently they discussed his loneliness and difficulties in expressing his feelings during childhood. This was followed by a flurry of projection upon the doctor of punitive motivation. Brink then joined a group discussion of the evil nature and dominant position of women and problems in acceptance by society.

Brink's mode of discussing his preoccupation gradually changed. His customary attacks on the doctor became shorter, and at times the tendency to attack disappeared. He joined with the others in discussing various themes but more often was the initiator. In Meeting 24 he brought out feelings on his passive, "sissy" role in relation to his mother, the doctor, and current authority and described his reaction formation against it. He discussed with Rutherford the question of releasing his feelings. In Meeting 25 and subsequent meetings he joined with Footer, Rutherford, Stunpf, Hilman, and Lobas in their intense discussions of submission, dominance, and homosexuality, with decreasing display of bitterness over other people's "spitting words"

at him. Watching the display of bitterness on the part of the other patients, he talked of the folly of his ways and of himself as an average man. In Meeting 28, after a prodromal attack on the doctor, he discussed his need for "psychological spankings."

He subsequently alternated between accusing his mother of having contaminated him with feminine ways and expressing his loneliness and guilt and his desire to change. At times, following the lead of other patients, he angrily accused the doctor of lack of interest and continued to link his past problems with his parents. However, he eventually joined the increasingly vocal, overtly cooperative patients like Sweet and Stunpf in their efforts to "face reality." Brink was improving.

Brink's course in treatment paralleled the course of certain others in the group. To summarize—while working out his extreme dominance-submission problem, which apparently involved catastrophic anxiety, he appeared to be fighting for survival. He worked through this problem in conjunction with two groups of individuals, one like Beaman, who showed up Brink's open aggression and resentment toward the doctor and the other, like Rutherford and Cursey, who were more passive and seductive. When he became accustomed to the doctor's attitude toward both types of behavior, he was able to react with more spontaneity and less guilt. Since the crises in which he had participated indirectly or directly had not led to catastrophic rejection, he was able to accept the doctor tentatively and to bring out other aspects of his problem.

As the issues of authority and homosexuality became openly ascendant, Brink repeatedly brought out his deeply ambivalent feelings about his parents and his preoccupation with and denial of his oral needs. He expressed overwhelming resentment against authority and dominating women and despondency about friendly relationships with his family and other members of the group. Sometimes Brink took the initiative in projecting motives upon the doctor and sometimes followed the lead of other patients.

To clarify further the case of individual patients we present the following sketches:

Beaman's defiance of the doctor, expressed in concert with Brink and other members of the group, was followed by a revelation of his seductive, homosexual ways, which he had attempted to sublimate by his preoccupation with activities and by keeping people at a distance.

Berg, who sat in the front row and was compliant and obliging to the doctor at first, gradually began to show sympathy with the members who expressed defiance, and in time showed silent antagonism.

Cursey, at first extremely and disconnectedly derogatory of the other patients, the doctor, and himself, gradually became clearer but even more bitter, at times joining with those expressing antagonism and defiance and also with those who usually reached out to the doctor. His deeply ambivalent preoccupation with moral questions was shown in his attitude toward homosexuality and the verbal assault on the doctor. He increasingly came out on the side of religious ideation and open, relevant antagonism to "punitive" intervention such as shock therapy—"You can't change it by putting me on the shock table and shocking me all to pieces." His former extremely veiled references to the evilness of woman and his homosexual tendencies became clearer, as did his guilt and need for acceptance.

Footer was currently much concerned about his difficulties with his wife. Like Brink he seemed to split his feelings between the doctor and Rutherford, with the doctor as the one hated and feared and Rutherford as the one talked to and accepted.

Gans at first routinely talked to the doctor only of high moral values and "safe" activities, in contradistinction to the "immoral" ideas and defiance of the doctor expressed by other patients. Gradually he unbent enough to attack certain group members and to defend others.

Hilman, after his preliminary attack on the hypocrisy of authority figures in general and the doctor in particular, appealed to the group and the doctor for acceptance. On being rebuffed by the group, he tried to sabotage the discussion by prolonged shouting whenever it was at odds with his rigidly moral attitudes. He congratulated the group in equally loud manner when it pleased him. Toward the end he participated in discussions in a fairly pertinent manner, but did not take the initiative.

Lobas gradually emerged from a cloud of verbiage aimed at the doctor, whom he accused of hypocrisy in belaboring the group for their homosexuality and lack of initiative. He was the first to accept the advances of Stunpf. After releasing a great deal of righteous indignation, he would display a fairly engaging personality.

Rutherford had experienced problems similar to Brink's and was one of his rivals for the doctor's help and attention. As various problems were acted out in the group, Rutherford and Brink formed a liaison. While encouraging Brink to accept the hospital situation and to adopt a less hostile attitude, Rutherford himself began to express resentment against the doctor.

Sheller, like Rutherford, maintained himself generally as a pro-doctor participant but asserted his rights as an individual in contra-



diction to the group and gradually came out with his despondency and resentment. Later he reported improvement in his visits home and talked about the purposefulness and hopefulness of the group.

## SPECIAL PROBLEMS OF THE LARGE GROUP

### *Initial Problems with the Aggressive Paranoid Patient*

This type was represented by Beaman and Brink, who from the first "saw" the doctor's blind spots and goaded him as hypocritical, rejective, and unhelpful. When faced with such an attack, it was necessary for the doctor to show his acceptance of the patient by giving serious attention to what was being said. Fight or flight only intensified the patient's image of the doctor as a hostile and guilty figure. If he was afraid of the aggressive paranoid type of patient, the doctor inevitably showed some blocking.

We found that the aggressive paranoid patient needed help in working with others of the same type before he could endure those who said openly, "Please help me." It was important that he be allowed to work through his panic and hostility toward the authority figure and then toward other patients in the group, before personal experiences were broached. It proved better to explore such material after the patient had reached the stage of joint effort. The support and security that came from being like others then enabled him to face his feelings of aloneness, hostility, low self-esteem, and guilt.

The following techniques proved helpful in clarifying the feelings of paranoid patients:

1. Slightly misinterpreting the patient's statement, so that he and other members of the group would repeat the original statement and attempt to clarify it.
2. Expressing the apparent meaning of the patient's statement and its opposite as possibilities.
3. Stating the obvious interpersonal process that was going on—for example, that the doctor recognized he was being verbally attacked and was putting up no defense.
4. Linking the patient's statement or attack with those of others—for example, by referring back to what was happening when the aggres

- sive patient began to show loud, domineering behavior. Linking him to others making similar statements usually brought out his hostility again but it also implemented an important therapeutic development.
5. Using any element of humor latent in the patient's production, if the humor was not derogatory, to ease tension.
  6. Giving the patient an opportunity to appeal for aid on his own terms by waiting for the verbal or physically threatening storm to die down.
  7. Accepting the idealism expressed by the patient as a basis for understanding him rather than something to be analyzed.
  8. Keeping in mind that the paranoid patient expresses the bitterness and suspiciousness repressed by the others. He thus provides them with leadership along this line, but when feeling favorably inclined, he can also guide them toward expression of tender feelings.

### *Initial Problems with the Hebephrenic Patient*

As with the paranoid patient, the clues to the therapeutic problem lay in the reactions of the doctor. The more anxious the doctor was made by bizarre, highly symbolic, sexualized, socially deviated, apparently hopeless behavior, the greater was the gulf between him and the hebephrenic patient. This in turn confirmed the tendency of the group to make a scapegoat of him. The hebephrenic, on his part, kept close watch on the staff and on the other patients for reactions to his bizarre utterances and behavior. Moreover, he often proved valuable as a weathervane in indicating trends of group development. In his symbolic, acting-out way he revealed what was in the others' minds days and weeks before they expressed it.

Sometimes the doctor used his own free associations as a guide in exploring the meaning and intent of the hebephrenic's production, sometimes he explored the hebephrenic by placing him in opposition to a paranoid patient. This was done by repeating the statements of both side by side, without commitment to either. Juxtaposing of the paranoid's feeling "I've got to have things a certain way, to the point of giving my life for it," and the hebephrenic's "nothing matters" made the sparks fly, at first at the doctor, then between the patients. The paranoid often tried self-righteously to suppress the hebephrenic,

but the latter usually came out on top in the encounter and received the appreciative laughter of the group—a valuable experience for him.

After the hebephrenic had learned that the doctor did not despise him or retaliate, he tended to introduce into the group situation extremely sado-masochistic relationships. The doctor found it best to handle this as part of the group process, rather than as an issue between himself and the patient. It became necessary at times to place certain restrictions on the hebephrenic's behavior, for his own and others' protection.

### *Initial Problems with the Catatonic Patient*

The mute catatonic caused an anxiety in the doctor which at times showed itself as helplessness and anger. This contrasted with his initial tendency to reject the paranoid and make a scapegoat of the hebephrenic. Verbal communications with the catatonic might be established fairly quickly through the inspirational atmosphere, but this was not usually possible or even desirable in the group setting. Relationships with other patients were therefore slowly developed on the basis of hostility as well as idealistic super-ego values. For a long while the doctor had to depend solely on non-verbal cues. During highly charged battles between divergent elements of the group the catatonic patient would sometimes make a high-flown declaration of love for both sides or a vindictive "plague-on-both-your-houses" speech. On the whole, however, the doctor did not urge catatonic patients toward active participation but merely followed their non-verbal responses to the appeals and hostilities of other patients. At times he briefly drew attention to the silent members of the group.

### *Promoting Group Interaction*

Besides the handling of specific types of patients, certain general problems arose in conducting the large group. In facilitating group interaction the doctor tried to shift the focus from impersonal issues to the preoccupations of members of the group. Starting with an issue of the moment (say on the question of whether the group felt that he could be trusted), the doctor sought the fullest possible spontaneous range of expression on this subject. When leaders of opposing

factions appeared, he guided the adherents of each side to comment on the other's position, and eventually on the relationship between their own positions and their attitudes in the group. By repeating pertinent comments, he then attempted to relate statements of various members to an underlying theme. Having thus brought to the surface a great deal of dynamic material pertinent to the group's tensions, the doctor watched to see how the patients interacted before proceeding to investigate their anxieties regarding him and one another.

Like dream material, the schizophrenic material brought out in the group had latent meaning which could be analyzed through study of group dynamics or through interview techniques. The former method was usually the more successful. For example, vague overtures by patients like Stunpf were often clarified by calling the group's attention to something the patient had said. In the case in point, Barkert or Cursey would usually present in a sarcastic, negativistic way one side of Stunpf's ambivalence, and Rutherford the other. Interview techniques, such as reflecting a remark back to the individual who made it, had the disadvantage of taking the initiative away from members of the group. Then the problem of relationships with authority figures would supersede the original issue. Interview techniques were best employed after the group advanced in its development to the stage where its rivalries had been worked out and prolonged discussion by an individual with the doctor did not result in too marked resentment on the part of the other patients.

All material brought out in discussions with the patients, whether in group meetings or individual sessions, was accepted by the doctor and at an appropriate time placed in an interpersonal frame of reference. Psychosomatic symptomatology, shouting, assaults, mumbling, self-flagellation, and so forth were all discussed with the group on the basis of "what this or that is doing to So-and-So." For example, sexual behavior was gradually transferred from its moral frame of reference to one which illuminated the defenses of the patient—sex used by one person to dominate another or sex as a dispeller of aloneness.

In focusing on the meaning of behavior the doctor used various devices. He might ask, "Let's look at what So-and-So is doing or covering up with such-and-such behavior," but such an intervention



required careful timing lest too much anxiety be aroused. It was best employed in reference to patients of an exhibitionistic type, and even here the doctor ran the danger of falling in with the propensity of such patients for bringing attacks on themselves.

Another device was guiding the group back to the point where discussion had been broken off by defenses such as indulgence in sexual gratification, vilification of others, or withdrawal, in order to define what had happened at that moment between individual patients and between the doctor and the group. In this process it proved highly important for the doctor to search within himself for the part he had played in the events leading to disjunction. But while it was helpful for him to realize the contribution his feelings had made to the block in treatment, it was unnecessary (and in fact inadvisable) for him to confess his mistakes to the group. Self-blame and other signs of guilt or anxiety merely increased the distance between the doctor and the group, whereas sober recognition of mistakes had the opposite effect. The group was reassured by the doctor's manner and prepared to try again with him.

#### SUMMARY AND IMPLICATIONS FOR THERAPY

In exploring the over-all problem of using analytically oriented techniques in group psychotherapy, we studied one large group composed of eighty-seven chronic schizophrenic patients. After a year and a half the group was regarded as functioning successfully and as possessing advantages of its own; the meetings were discontinued because of termination of the project. Records were kept of dynamically significant changes in the ways in which patients participated, and inferences were drawn as to the therapeutic techniques employed. Our experience not only demonstrates a method of preparing patients for small-group and individual therapy, but also indicates that groups of as many as eighty-seven patients can be conducted with therapeutic effectiveness.

All except a few of the most withdrawn patients showed acceptance, however ambivalent, of the purposes and procedures of group treatment. As they proceeded through the opening skirmishes of treatment, they appeared to let down some of their defenses against participation

in a venture with a doctor who was obviously attempting to change their attitudes and ways. For some the course of illness seemed to have been reversed. They had gone through defenses against feelings and, short of mayhem, a display of these feelings. They had learned that they could talk together as individuals and that, in so doing, they could gain something from one another. They had participated in experiences which raised their self-esteem through mutual support and expression of emotion. They had done this together—at first against the doctor, then against one another, then with and for one another.

As in the case of the smaller groups discussed in previous chapters, the development of the large group progressed by distinct stages. There was, however, a certain amount of overlapping, since the characteristics of each stage continued to appear in varying degrees. This development may be recapitulated as follows:

1. Brief introduction to concepts and purposes of therapy given by the doctor. Projection upon the doctor of images of omnipotence, malevolence, and hypocritical aloofness. Patients dissociated.
2. Projection upon the doctor of images of seductiveness and desirability, as well as malevolence and rejection. Beginning of rivalry for the doctor's attention and of hostile interchange among group members, who communicated aspects of themselves apparently without awareness.
3. As the hostile interchanges intensified, they crystallized into themes later discussed by the group; submission to the domination of those in authority and of evil woman, homosexuality and the status of homosexuals as outcasts. The group made an attempt at social control as individual members displayed their feelings to the doctor and to one another.
4. Individual patients associated personal material related to themes. They became gradually freer and more affectively involved in associating to the material brought out by one another. Indications of intense transference to the doctor and to fellow patients appeared. Intra-group hostilities were marked but controlled and the patients began to accept friendly overtures from one another. Individuals became increasingly integrated into the group discussion, and leaders emerged as problems were worked through.

In group therapy as in individual therapy the doctor has a broad responsibility in the treatment procedure. It is on his initiative that the group assembles. He has to be unrelenting in his attention to the phenomena and expressed needs of the group in order to guide the members toward or around their areas of greatest anxiety. In this process he must be free to face the anxieties which interfere with his proper functioning as a therapist. He needs to:

1. Orient the group to the therapeutic experience
2. Train the group in the discussion procedure
3. Help the group to arrive at meanings
4. Channelize issues for group surveillance and help bring the members back to issues they and he have side-stepped
5. Interpret behavior and content in interpersonal terms
6. Act as a communications expert by keeping the channels of communication free for all, intervening at times against domineering patients and bringing out the withdrawn ones
7. Help patients to work through their underlying anxiety and their hostility toward one another and the doctor
8. Use his awareness of his own associative processes and feelings as a guide in the treatment process
9. Use the group as a means of support for the individual by encouraging members with similar feelings to verbalize them at the same time
10. Encourage relevant associations to material brought out in the group
11. Use the group to demonstrate that the areas of experience forbidden to the individual by his anxiety can be successfully entered by others in similar predicament

## APPENDICES





## APPENDIX A

### *Running Accounts of the First and Sixty-Fifth Meetings of the Same Group\**

---

#### RUNNING ACCOUNT OF DR. N'S GROUP II, MEETING 1

THIS account was selected because it illustrates the variety of problems that arise in a first meeting and ways in which patients try to deal with them. Bly was the only patient in this group who had had individual psychotherapy. One had seen the doctor twice; the others, once. All knew that the doctor would not make appointments for regular individual sessions and that, as far as possible, therapy would be confined to the group. The doctor was experienced in therapy but had conducted only one group previously, and that group with concurrent individual sessions. He decided to let relationships among the patients develop spontaneously as far as possible (hoping in this way to bring neurotic patterns to light most rapidly) and to comment chiefly on the ways patients related to one another rather than on the material produced by any one patient. As will be seen, however, he tended to get into discussions with individual patients—probably because of his much greater experience in individual than in group therapy. Thus the entire situation became one of considerable confusion and tension.

PRESENT: Bly, Dupont, Flower, Hare, Ingram,  
Mason, Null, Pim, and Teaney

#### SEATING ARRANGEMENT

	Pim	Flower
		Null
Hare		Bly
Mason		Dupont
Teaney		
Ingram	Dr. N	

\*For a description of the technique developed for writing the running accounts, see Chapter II.

## SUMMARIES AND INFERENCES\*

## OBSERVATIONS

(1) When Hare asked for directions from the doctor, seconded by Mason in a *community of feeling*, and Teaney in a less related way indicated his anxiety about the nature of the meeting, (2) Dr. N drew a parallel to individual sessions. *Listing topics may have been due to his insecurity.*

(3) A second *community of feeling* followed, when Mason expressed his personal feelings, seconded by Hare, and Teaney indi-

Dr. N asked the men to take seats in a prearranged circle of chairs. He assured the group that all records of what went on would be as confidential as those of individual sessions. He introduced the observer, known to most of the patients because of his initial interviews with them. Having listed on the board alternate times for a second weekly meeting of the group, Dr. N asked who could not attend at these hours. Deciding to postpone agreement on the time for the second weekly meeting until all were present, Dr. N then asked whether anyone wanted to bring up anything. There was a silence. "It is always hard to start," he said.

(1) Hare asked, "Just what should we start out with?" Mason added a similar question. Teaney wondered just what was going to take place. Hare: "It's cold walking in from the street. Just what is the score here?" Hare was looking in his wallet as he spoke.

(2) Dr. N suggested that problems to be discussed in the group were the same as in individual interviews; he reviewed possible topics: mothers, work, women, hostility, service.

(3) Mason said he felt a strain in situations like this. Hare said, "Yeah, like an interview for your first job." Teaney told Dr. N that

\*Inferences are italicized; the numbers refer to corresponding observations in the opposite column.

SUMMARIES AND INFERENCES

*rectly attacked Dr. N, vaguely joined by Hare.*

(4) Dr. N seemed acceptant of the attack, inviting further group discussion. Getting none, Dr. N returned to the originator of the attack (*putting the patient on the spot*).

EFFECTS:

(5) Teaney retracted, and also Hare, and Bly spoke up for psychiatry.

(5a) Then Teaney revealed his distrust of others and his own helplessness.

(6) Dr. N indirectly stated the mores for the group—that it would be acceptant of what might shock a social group.

OBSERVATIONS

on Thursday night he had heard a minister say he had no faith in psychiatric treatment. Hare responded that the minister had gone further than psychiatric treatment. Teaney said the minister could understand problems but that wouldn't help Teaney.

(4) Dr. N asked if others had had a similar experience with ministers. No response. Dr. N asked if the minister's remark had made it difficult for Teaney to come here.

(5) Teaney said, "No," he'd heard good things about it. Hare said perhaps religion had failed. Bly said that through a psychiatrist he had learned to control his outward condition. He had lost confidence in doctors before that. Pim entered at 2:45 (fifteen minutes late). Bly went on talking. Dr. N indicated a seat to Pim.

(5a) Teaney: "May I say something?" Dr. N: "Surely." Teaney: "I find difficulty in confiding in friends . . . they'll know everything about my life—and that won't help me." Bly: "That's why psychiatric treatment is necessary." Pim sat stiffly surveying the group; Null was smiling blandly; Dupont was looking at his foot; Ingram was slouched in his chair with his hands in his pockets.

(6) Dr. N: "One advantage of this (group therapy) is that it is confidential. But friends can bring a layman's point of view. . . . The



## SUMMARIES AND INFERENCES

EFFECTS: First, the group was silent.

(7) *Then Pim, who seemed least able to bear silences, presented the problem of a person twice removed from himself. His apology for his contribution suggests his awareness of his own evasiveness. The point that the friend did not accept his wife's problems may have been an indirect expression of Pim's fear of the group's rejection of his problem.*

(8) Hare again asked Dr. N to give directions. Bly took over as a sort of assistant therapist, indicating that he knew about psychotherapy. *Intending to justify himself to Hare and to set the mores,*

(9) Dr. N supported Bly. After a pause, (10) Pim sought answers directly from the doctor again and the doctor took over as the group leader.

(11) Dr. N accepted the complaints of three patients about the

## OBSERVATIONS

advantage of this group is, we're not shocked." Short silence.

(7) Pim: "Dr. N, I had an experience with a close friend. . . . His wife was a psychoneurotic case herself, paralyzed to meet people. . . . My friend said he didn't see how his wife could feel that way. I don't know whether that's in order—or the topic of conversation."

(8) Hare, impatiently to Dr. N: "Couldn't you control the point?"

Bly: "I know what you're getting at. While I was hospitalized, I was in group therapy—you find yourself bored and it makes no point." He then explained that he was here because he couldn't get private treatment and that it takes time to allow "a gradual moving together in the group."

(9) Dr. N: "From our experience, we would say the same," adding that it was easy to be bored. Slight pause.

(10) Pim asked Dr. N what points had been made before he came. Dr. N reviewed and at this point decided with the group that the second weekly meetings would be on Tuesdays from 8:30 to 10:00 A.M. Bly said that getting away from work on Tuesdays would be a problem. He mentioned having to see the clinic psychologist four or five times.

(11) Dr. N suggested that twice was enough. "Anyone else have

SUMMARIES AND INFERENCES

psychologist at face value, instead of considering them also as *possibly devaluing therapy through attacking a member of the clinic team. In taking over sole responsibility for the situation he seemed to encourage dependence on himself, as shown by Pim's then asking him to assume further responsibility for getting therapy started.*

(12) An invitation to Pim did not succeed in getting him to take the initiative.

(13) Bly's generalization brought responses from Mason, Hare, and Teaney.

(14) When Dr. N singled out Teaney for comment, Hare cut in. When Bly made a comment and Dr. N rephrased it, (15) Teaney did not respond, perhaps *indicating that an interpretation given by a patient might have threatened a defense which Teaney needed to retain until he had enough support.*

OBSERVATIONS

a similar problem?" Mason said that he had had to come in every day that week. Teaney: "I've been two or three times a week." The eye clinic had him tied up, too. Dr. N inquired about the rest, then asked Ingram directly, "Anyone else? I'll try to get that straightened out." Long silence. (So far, Flower, Dupont, and Null had made no comment.) Pim: "Doctor, it seems to me there should be a starting point." All laughed. Bly: "Whoever has guts enough to start?"

(12) Dr. N to Pim: "You'd like to start?" Pim: "I hoped you would start us off. You've had other groups."

(13) Bly suggested that a loss of confidence prevents people from doing things. Mason asked whether with self-confidence one could do anything. Hare made a joking comment. Teaney asked whether with confidence one could do anything. Bly said that if he had confidence he wouldn't be sitting here.

(14) Dr. N: "I'm not sure what you mean, Mr. Teaney." Teaney talked of church and of others' expecting him to be better than they were. His voice quivered. Hare cut in: "Is that an attitude we set up?" Mason: "I think so." Teaney: "I don't like people telling me what to do." Bly said that lack of self-confidence leads people to feel that others jump on them.

(15) Dr. N rephrased Bly's com-

## SUMMARIES AND INFERENCES

(16) Dr. N's attempt to draw Teaney out failed. Bly succeeded then as *assistant therapist*.

(17) Hare repeated his attempt to get the doctor to give directions whenever silence occurred. *Tension was dissipated by laughter.*

(18) Pim introduced the topic of expressing one's feelings, talking with Dr. N in a semipersonal way until Teaney became personal. Mason and Ingram joined in, generalizing.

## OBSERVATIONS

ment. When Bly amplified this, Dr. N asked that he be more specific. Ingram immediately spoke in general terms about over-confidence. Bly said that over-confidence is like lack of confidence, and Dupont nodded in agreement. Bly described feeling low and lacking confidence in himself. Dr. N: "Mr. Ingram, do you feel that?" Ingram shook his head. Teaney: "Often really humble people act sophisticated. You can't tell whether they're acting or real." Ingram commented, generalizing. Hare said, "That's the problem here. We're being humble in not talking." Teaney: "I can talk if the rest of you can." Short silence. Pim said that self-confidence may be an "armor against inferiority."

(16) Dr. N: "What do you think of that, Mr. Teaney?" Teaney said that he was "just staying out of the picture." Bly: "Don't you find people notice you more often than not?" Teaney: "Yeah, I don't know if it's true, but I feel that way." Bly: "Me, too." Brief silence.

(17) Hare: "Where do we go from here?" Laughter.

(18) Pim: "I can't show my own emotions. Others who do, bother me." Dr. N: "You say you're bothered by. . . . Can you give us an example? That might help." Pim: "I can't see going overboard at

SUMMARIES AND INFERENCES

(18a) Bly made an observation about the group members' being "introverts." Gradual and oscillating progression toward self-expression with rising tension. This led to personal discussion involving Bly, Pim, Mason, and Teaney about letting oneself go (*rallying topic*).

(19) Dr. N's *somewhat gratuitous*

OBSERVATIONS

football games for three-quarters of the game. I consider it lack of consideration for the other people." Dr. N: "Is it that their expression of emotion interferes with you?" Pim: "That's part of it, but not all." Teaney: "Afterwards, I think how silly I was when I expressed emotion." Pim: "Actually, is it silly?" Mason: "I think that's what they go to games for. To let inhibitions go." Ingram said that people just get so involved in the game they don't know what they are doing. Pim said that they are no longer really concerned with what they do. Bly said that they are not self-centered. Pim: "That's right."

(18a) Bly deduced from others who had spoken: "You all seem more or less to be introverts. That may be perfectly normal due to breeding." Pim attributed this to causes way back, to years of home training on the things to do, adding, "It built up an impression of those who let go." Bly: "I get pressed up inside." Mason asked whether Bly would feel relieved if he let himself go at a football game. Dupont turned to look at Bly (Dupont frequently went to football games). Bly said that he liked to go, but that he couldn't keep going to football games to get relief. Teaney said that he got headaches at football games. Bly: "I get headaches every day without football games."

(19) Dr. N said rather abruptly,



## SUMMARIES AND INFERENCES

*comment, intended to relieve tension*, resulted in (20) Hare's gibing at him.

(21) Dr. N intervened to let the topic Pim brought up continue.

(21a) Pim continued with other examples after indicating that Dr. N should give the answers. Bly remained active.

## OBSERVATIONS

"Feel free to smoke. . . . I'm not a smoker myself."

(20) Laughing, Hare said the ash trays already indicated that smoking was okay.

(21) Dr. N: "We ought to stay with the business of pent-up emotions. Just because we have been trained not to show them, why should it make us angry at those who do show them?"

(21a) Pim said that he didn't know and would like the answer. Dr. N asked for further examples. Pim talked of parties and loud laughter's attracting attention to the table where it arose. Bly said that the same thing bothered him when his wife and he discussed prices too loudly. "It builds up aggravation. Why, I can't tell you." Pim said that actually there was no reason why one shouldn't discuss prices, especially if one has limited resources. But loudness attracts attention. Dr. N pointed out that in the examples given "attention was not attracted to you"—at football games and parties. Pim said there were distractions present. Mason suggested that not attracting attention was a matter of general pride. Pim agreed that pride had something to do with it. He considered loudness a breach of good breeding and spoke disparagingly of artists and Bohemians. Mason agreed, but said that he wouldn't let others' bad manners bother him. Ingram said disapprovingly that

SUMMARIES AND INFERENCES

OBSERVATIONS

(21b) Bly, *continuing as assistant therapist*, cautioned Hare, saying that more time was needed; *Bly knew how therapy should proceed.*

(22) Hare began to speak about his own feelings, but Mason, who had repeatedly followed Hare's lead, now began to complain of his wife and his own impossible lot.

some people didn't "appreciate good manners," and Bly contended that this wasn't the point. Hare cut in on Bly, but then said that Bly should go ahead, which he did at some length, until Pim cut in to tell of a boy he had grown up with, and with whom he had recently argued about paying a dinner check. During this, Dupont seemed pensive, Bly sat with his chin in his hand, Null wore a wry smile, and Flower looked attentive. Pim talked on. Hare looked interested, Mason laughed, and Teaney looked down blankly, as Ingram yawned. Finally Hare said, "Excuse me, but we want to discuss the feelings behind paying for the dinner check."

(21b) Bly said he thought they were just getting to that: "This is an opening wedge. I don't think you can go too far (rubbing his head) too fast. I get irritated with people for being petty." Pim: "Does that come from a feeling of anxiety? I want to get things set and pay the check fast."

(22) Hare: "I wonder if anybody's found. . . ? Well I just find that I rush by and ignore people. We think everyone else is wacky." Mason: "That sort of strikes home. My wife argues with others over the children (Dupont looked up at the speaker). . . . I jump on my wife and tell her to shut up and humiliate herself a bit." Pim: "I wonder if she'll profit by humbling herself? I'd rather get an

## SUMMARIES AND INFERENCES

(22a) Hare *implicitly asked for Dr. N's direction.*

(22b) Bly replied by trying to shift the focus back to themselves rather than their wives, Pim again fleeing to generalities, Hare joining them *in a community of experiences.*

## OBSERVATIONS

argument over with. The other fellow can have his own way." Mason then explained at length: "Well, my wife's in a sickly condition. . . ."

(22a) Finally Hare said, "We just don't have any solutions here." Mason felt that his approach with his wife offered the lesser of two evils.

(22b) Bly: "Getting a little more personal, (to Mason) don't you find yourself bawling your wife out when you do something wrong?" Mason said that he didn't believe he took it out on her. Bly explained his reason for asking—"I find myself exhausted, and. . . ." Mason said he'd been in that situation; things may be hot for about ten minutes but he sees that he gets them over with. Teaney questioned Mason, saying that he lets things drop himself because he knows his feelings won't change. Hare said that it all went back to the same thing: "We don't give the time to others that we should." He said he thought that his wife had the same attitude. Pim, Teaney, and Mason all started to talk at once. Pim noted that anxiety blocks one's concentration and vision. Mason spoke of lack of patience. Hare asked what caused this lack of patience: "I've never had patience for anything." Mason: "Nor I." He mentioned his mother's bawling him out as a kid. Bly: "I find I can't slow down. My only relaxation is when I slow

SUMMARIES AND INFERENCES

(22c) When Dr. N encouraged their talking about specifics, Mason continued with his long complaint, and finally Hare criticized his own wife. The level of discussion kept getting more and more personal for Mason and Hare, although they were attributing their difficulties to others and to external circumstances.

OBSERVATIONS

down, but I must keep at top speed—and get nowhere.” He resented being hurried, yet he pushed others. Mason: “I agree with you.” Hare: “What is this thinking that’s causing this?”

(22c) Dr. N: “Sometimes it helps to take specific examples. We’re talking of generalities here.” Mason: “I’ll give you a specific example. My wife had a baby in June. Since then she has been under doctor’s care. By the way, she’s very high-strung emotionally. She’s hard to get to the doctor. Usually, that condition would have been cleared up in two or three weeks. . . . In addition, my boy has asthma. We have baby trouble too, and with all these things there is nothing I can do to clear them up. . . . Asthma is a lifetime condition. These problems are always on my mind. The doctor is afraid of a nervous breakdown in my wife.” In various ways Mason said that he always had these problems before him and that there was nothing he could do about them. As he spoke, all the other members looked at him attentively. Pim asked whether these matters upset Mason too much for him to consider other matters. Mason: “Yes, entirely, my attitude is affected. My wife is in a semi-invalid state. Because of our financial condition, she does all the housework. I try to keep myself from more mental stress, but I come home to hear of my



## SUMMARIES AND INFERENCES

(23) Dr. N wanted the meeting to become more therapeutic through *self-analyses* (T).<sup>\*</sup> His maneuver failed at first, even though Bly responded with a statement about his dependency on his wife. Mason continued to criticize wives. However, Hare began to focus on himself and was followed by Bly.

## OBSERVATIONS

wife and children and trivial things. I have to keep it all in." Mason then told of a long spat his wife had with a neighbor, a "she-devil." Null smiled as Mason described this episode and stifled a yawn. Mason continued, "Things just keep coming!" Hare: "Isn't that perfectly normal? My wife is highly emotional too and has trouble with neighbors upstairs." Although his youngest daughter is spoiled, he said, "The kid is brilliant at times." Hare tried shrugging off Mason's troubles, saying they all went back "to that fellow's statement there (Bly's remark about taking it out on one's wife—22b)."

(23) Dr. N talked at some length, saying that the patients had brought out how their wives upset them, but that he wondered how they affected their wives. Bly said that his wife periodically got upset, but added, "When I'm ready to pass out, she's part of me." Mason: "I think the highly emotional type carry their concern overboard." Bly suggested that some wives sense their husbands' insecurity in certain situations. Hare: "That's my point." Dr. N to Hare: "Want to elaborate?" Hare said that he came from Massachusetts and neither he nor his wife liked Washington. Mason cut in to ask how long they had been there. Hare said he was not

<sup>\*</sup>(T) indicates that the doctor (therapist) made the preceding statement to the observer after the meeting.

SUMMARIES AND INFERENCES

(24) Hare questioned Bly, *seeking a community of feeling*. This was later openly expressed by (25) Mason and (26) Pim. Pim became more personal than at any other time but immediately retreated to generalizations and willingly relinquished the floor to Bly.

OBSERVATIONS

content to live there, although they had been there since he went into service. Looking at Mason, Hare said that he was stating the matter baldly without arguing about it, but that he just didn't like his work and was bored with it. Another turmoil was with his wife. He thought sexual interest had a lot to do with their attraction, but it was the basis for a terrific emotional situation. Bly said he didn't care for Washington. He had come there as a means to an end. He was afraid of losing his job; he was relaxed only in the mornings and that was how he got through his work. Null smiled at Bly. Bly said that he was useless in the afternoons, accomplishing nothing—"just beat up . . . in my case a physical condition."

(24) Hare asked whether boredom in his work was not a cause. Bly: "No, I'm afraid not." He intended to go out on his own when he got enough of a sense of security. Dr. N: "Many things can make a person nervous." Bly agreed that there are a lot of them. Pim thought Bly sounded as though he lacked self-confidence and asked whether he had ever accomplished anything: "Can you put your finger on something?" Bly: "If I could. . . ." At evening law school, he was keyed up from his day's work. At certain times he just sat through class and felt completely confused.

## SUMMARIES AND INFERENCES

(27) Questioned by Pim, Bly at first tried to put the blame for his condition on his physical state. Dr. N did not want the group to continue to discuss somatic complaints under Bly's lead (T).

(28) He therefore immediately tried to redirect Bly's approach by getting him to express his hostility toward doctors and other interpersonal difficulties. Bly described his feelings under Dr. N's questioning. The effect of this was that Hare and Mason became derisive, *perhaps unready for Bly's out-pouring or irritated at the doctor's attention to Bly*. (During Mason's earlier monologue on his wife, Dr. N had not commented but had indirectly indicated his

## OBSERVATIONS

(25) Mason said that he knew exactly what Bly meant: "I've had that myself." Null smiled again. Bly said that when he went to discuss things with his chief, he couldn't think clearly.

(26) Pim seemed most attentive to Bly and then said, "I have the same problems myself. So many thoughts are going through my mind. I'm off on half a dozen things." Between anxiety and fatigue he was "nearly beat." "What the answer to that is, I don't know. . . ." But coming back to that feeling of confidence, Pim asked, was Bly shattered by running into these situations? They affected Pim that way.

(27) Bly: "My basic fear is worry about a physical condition." Pim: "Really?" Bly worried about his physical condition, irritability, and an infection that had not been taken care of in the service. He told at length of how he could have lost an arm.

(28) Dr. N: "You feel your condition is due to infection?" Bly: "No." Dr. N: "Any idea what it might be due to? Something like your relations with people? You said you had to argue with the doctor." Bly said that this doctor had a reputation for incompetence and that he was lax in treatment. Dr. N: "Did you know that at the time?" Bly: "No, but I was friendly with the other doctors. They told me. . . . I know that that isn't the root of my problem."

SUMMARIES AND INFERENCES

dissatisfaction with the content of the speech—see 23.)

(29) Bly met the derision with a defense.

(30) To give Bly permission to be angry Dr. N indicated his awareness of and readiness for Bly's feelings of hostility (T). Mason's first response was a dig at Bly. After Bly had expressed his hostility toward doctors, Hare *took another indirect poke at Dr. N and Mason subtly joined in. Dr. N's implied invitation to Bly produced expressions of hostility from Hare and Mason.*

(31) Dr. N wanted to show Bly that he knew Bly was still hostile to doctors (T).

(31a) Null, though silent, *seemed to be involved.*

(31b) Bly then poured out his anger at having been treated badly by incompetent doctors and at not having been given his just deserts.

OBSERVATIONS

Bly then told of his habit of picking at hangnails and of being told that this was dangerous. Hare laughed, Mason too, exhaling noisily.

(29) Bly said he was opening up because someone had to. . . . He explained, "It's not purely an infection, but the terrific headaches and tenseness and pain in the top of my head, making for a vicious cycle."

(30) Dr. N: "There may be a lot of anger tucked away with fears like that." Mason: "I've been picking at hangnails for years!" Bly said he was trying to get rid of the things, like fear, behind this. Hare said that Bly's suggestions had got him to thinking. Bly said that he had developed a general loss of confidence in doctors. Hare: "I don't think that's too bad an idea." Mason: "That's being practical."

(31) Dr. N to Bly: "Why put that in the past tense?"

(31a) Null snickered.

(31b) Bly then began to express his negative feelings toward all doctors, the ones in Cincinnati and Letterman Hospital. He had had to prove to them that he was sick and his sickness was not "all in the mind." Speaking with obvious irritation, he went on, "I say I can't live a normal life in the service. I deserve help toward recovery. I feel it should be done.



## SUMMARIES AND INFERENCES

## OBSERVATIONS

Before I went in the service I'd think people I saw were crazy." Mason asked abruptly what kinds of people he meant. Bly amplified about their jitteriness and added, "Now I have it myself." Dr. N announced that they would have to stop and added that they could all see they had things to talk over. He said that they would meet again on Tuesday and then checked to see who would come. Ingram was the first to say, quite meekly, "Yes, I'll come then." The others indicated that they could or could not come. As the rest left the room, Null walked over to tell the doctor that he could not come on Tuesday. He added, "I'd say it was a very good discussion," yet implied that it had been of no help to him. "But it was very interesting and everyone looked so normal."

SUMMARY OF THE MEETING BASED ON THE  
DISCUSSION BETWEEN THE DOCTOR  
AND THE OBSERVER

*The Doctor's Reactions and Goals*

The doctor thought that his goal of starting group interactions had been realized. His own feelings during the meeting were about as follows: First, he had been slightly ill at ease when challenged by Hare, Mason, and Teaney; then he struggled not to get involved with any one patient. He was uneasy when Hare and Mason brought up personal matters before there was any support from the others, but he relaxed as the group loosened up and active participation spread from Pim to Bly, Mason, and Hare and as the others looked more interested.

His goal for this meeting had been to break the ice. For the next meeting his goals were: (a) to help the patients bring out more specific

and more personal material, (b) to encourage the expression of emotions by indicating that any feelings were acceptable even though hostility without positive feelings might disrupt the group.

### *Group Dynamics*

This opening meeting seemed to move from evasiveness through considerable generalizing and circumstantiality, to revelation of rather personal material and finally to open expression of rather intense hostility by at least one member (Bly). This seemed to be related to the nature of the doctor's interventions and to increasing indications of the development of a community of experience on a more or less superficial level. For example, Hare and Mason expressed similar initial feeling about needing direction from the doctor (1, 3). Pim and Teaney expressed similar feelings of embarrassment about the expression of emotions (18). Hare, Mason, and Bly described repeated experiences with and feelings about their wives (22, 23). Confusion and fatigue on the job were shared by Bly, Mason, and Pim (24, 25, 26). Beneath the surface, Hare, Mason, and Null probably shared more of Bly's hostile feelings toward the doctor than any of them expressed (28, 30, 31, 31a).

### *The Doctor's Interventions*

Dr. N felt that he had turned to Teaney most because Teaney was "the sickest patient in the group." He thought that his focusing so much on one member was counter to the group interest (14, 15) and that it led the other members to intervene. He thought that his attempts to set up group mores explicitly (2, 6, 9) led to pauses and silences and that perhaps mores were established more effectively by demonstration and implication. The doctor's method of dealing with hostility seemed particularly significant. His initial handling of Teaney's hostility (4, 14) led to the latter's withdrawal. Invitations to express hostility were apparently premature in the first meeting. As a result of the doctor's encouragement near the end of the meeting (28, 30, 31) Bly expressed his anger and two other patients subtly attacked the doctor. It might be speculated that the intervening expressions of community of experience and emotion among the members gave these patients enough mutual support to enable them to express their hostility toward doctors.

### *Behavior and Psychodynamics of Individual Patients*

Bly moved through three phases in the group in Meeting 1: (a) He took the role of leader, perhaps trying to show that he knew his way

around or seeking approval from the doctor. Dr. N felt that Bly was trying to propitiate him. Strong anger seemed to underlie his efforts to control the group. (b) He gradually talked less of his feelings, insisting that his basic problem was physical. Dr. N's questioning caused him to change this approach; (c) he then became angry, expressing hostility toward doctors but avoiding any direct attack on Dr. N. He was intellectually keen and used his capacity to serve his need to dominate. Dr. N predicted that Bly was going to be a problem.

Dupont was silent throughout the meeting. In the first part he gave no evidence of being aware of what was going on, but he gradually became more interested and finally seemed to Dr. N to be quite involved when Bly became hostile.

Flower was also silent throughout the meeting. He seemed interested when Bly became angry at the end of the meeting.

Hare surprised Dr. N by being so candid. He was, however, extremely ill at ease, looking to the doctor for guidance and apparently angry because he was not getting it. He talked about himself and his hostile feelings; he was reluctant to go on, but did so in a fragmentary and thoughtful way. He was apparently dissatisfied with the group's pace and by implication kept anxiously suggesting, "Let's get organized." Perhaps to his own surprise, he found himself speaking critically of his wife. He exchanged many anxious looks with the doctor, who felt for him more than for anyone else in the group.

Ingram seemed to be trying to be a good boy, apparently speaking because the doctor wanted him to, but nothing really touched him. His generalizations may have impeded the group's moves toward consideration of specific experiences, feelings, and problems.

Mason behaved according to the doctor's predictions. He followed Hare's lead in requesting the doctor to give directions. He finally presented his problem in terms of blame for his wife. His attitude was an aggrieved one ("poor me"). He complained, dramatized, and sought sympathy. He did much agreeing and interacting with Bly and Hare. The doctor thought Mason might facilitate interactions in the group as time went on.

Null acted as if he were a superior person who had come to observe the rest. He had a thick shell but much anxiety underneath. Although silent, during the meeting he seemed quite involved at times, especially when Mason spoke of difficulties between his wife and a "she-devil" neighbor. He exchanged glances with the doctor, perhaps thinking of his ex-wife. After the meeting he spoke to Dr. N.

Pim was more self-revealing and serious than had been expected. He apparently found the silences harder to bear than the others did.

His typical maneuver was to initiate discussions and then to generalize or shift the focus to another patient when the material seemed about to become personal. He seemed to need to have the doctor's directions. His attitude was "I'll go so far and no further." His verbal facility and superficial poise permitted him to participate actively without any real involvement.

Teaney surprised Dr. N by coming out with personal material. He seemed, however, basically out of contact with the others. He might have said what he said in an empty room; he did not really seem to mean it. His opening remark, in which he questioned psychotherapy, was a stumbling block. Dr. N felt an underlying hostility.

# RUNNING ACCOUNT OF DR. N'S GROUP II, MEETING 65

THE patients who attended the 65th meeting of Dr. N's Group II were experienced in group therapy. All but Coombs (who had joined this group in Meeting 61 but had had extensive group and individual therapy with Dr. N) had been meeting together from the inception of Group II or soon thereafter. Their familiarity with therapeutic mores and with their fellow members made possible direct and forceful expressions of feelings in which transference reactions played a large part. This was in contrast to the tentative and hesitant behavior of the first meeting, in which members were chiefly concerned with sounding each other out and trying to discover what was expected of them.

PRESENT: Bly, Castell, Coombs, Ingram, and Veal

## SEATING ARRANGEMENT

Bly	Veal
Dr. N	Castell
Ingram	Coombs

## SUMMARIES AND INFERENCES

## OBSERVATIONS

The observer entered the room with Castell, Coombs, Bly and Veal were laughing and chatting. They seemed to be focused on Veal, as they were turned in his direction. When Dr. N entered the room a minute or two later, the men stopped laughing and looked at him as though waiting to settle down to business.



## SUMMARIES AND INFERENCES

(1) The doctor began by referring to the episode with which the previous meeting had closed.

(2, 3) Not getting the desired response, he immediately turned to other members.

## OBSERVATIONS

(1) Dr. N began the meeting in a very businesslike manner with, "We have some unfinished business from the last meeting. For the first time Mr. Bly expressed real anger." Bly: "Yes, I was really mad last time." The doctor turned to him and asked, "Is there enough of it left to go into now, or shall we wait until it comes up later in the meeting?" Bly replied, "No, I can go on now—I guess I was feeling better but it came up again." Bly stumbled on, as though having difficulty in getting his thoughts out, and then said, "I guess I had better wait until later on." The doctor said, "Okay, we can wait until it comes up later." There was a short silence. Bly began to tell some of his feelings about the V.A., but again stopped short before he had said more than a word or two. There was another silence.

(2) Dr. N: "Would any of the others like to comment on what happened last time?" Coombs: "When he (indicating Bly) got angry, I had respect for him." Dr. N: "He seemed to have more for himself." Bly: "I did. Last time I had the feeling I was starting to control the situation myself, without having you to control it for me. I have the idea that if I could just get to that point, things would be okay." Ingram entered and Coombs smiled at him and said, "Hello!"

(3) Dr. N explained to Ingram,

SUMMARIES AND INFERENCES

OBSERVATIONS

"We were talking about what happened last time—I wonder if you had any feelings about it." Ingram replied quickly, "No, nothing particular." Silence. Bly: "I think the crux of the matter with me now is, to respect myself, I have to feel that things exist as an outcome of things that have happened in the past." Dr. N turned to him questioningly, "If you can blame external circumstances, then you'll feel okay?" Bly: "Yes, that's what I think it is." Dr. N: "It may be that real self-respect comes from recognizing your own weakness." Bly: "I think I can recognize my weakness, but I don't want to feel I deliberately brought this on myself. Like in the service—if they agreed it was an illness, then I would have self-respect. Otherwise, I deliberately went through all that stuff just to get a discharge." Dr. N: "If *they* thought your trouble was physical?" Bly explained who the *they* were: the entire public, his family, and so forth.

(4) Dr. N's attempt to draw in other members was defeated by Bly's rushing in, *suggesting that he was unwilling to relinquish the focus.*

(4) Dr. N: "Does anyone else want to contribute to this really important matter that one must have no weaknesses?" Bly: "If I could say, 'Well, I did have a situation in the war—I was overworked, and that sort of thing,' I could have respect, but since psychiatry is such a sore spot in America, I developed such a lack of trust in doctors, even you (indicating Dr. N). They've all treated me the

## SUMMARIES AND INFERENCES

(5) *Ingram's real concern seemed to be his feeling, which he had brought up in the past three meetings, that the doctor was putting something over on him.* He came to this point again, later in this meeting (see 11).

(6) After initial hesitation, the doctor decided to answer Ingram's question at face value, to avoid the appearance of rebuff, to which Ingram was particularly sensitive, and to use the visitor's statement to further his goal of calling the group's attention to their hostility to him (T).

(7) *Bly's great need for approval was illustrated by his reading it into the visitor's attitude.*

## OBSERVATIONS

same way. I've got to make someone treat me differently." Dr. N: "Hm." Bly: "Coming over here today, I wanted to get hold of that V.A. fellow, to tell him of my situation." There was a long silence. (Castell looked intently at the observer.)

(5) Ingram: "Just out of curiosity—that fellow who was here last time—I saw him writing notes. What was he taking down? What was it to him?" Dr. N: "What did it mean to you?" Ingram was non-committal.

(6) Dr. N continued, "Well, I think it's much too general a point to be of much use, but I'll tell you." Dr. N went on to tell the group about several specific points which a visiting doctor\* had observed—the constraint in the group over Coombs' presence, which Dr. N had also mentioned to them last time, and the hostility toward the doctor, which the members had not been able to bring out. Dr. N then asked Ingram, "What kind of thing did you have in mind?" Ingram: "I was just curious about the type of thing he could possibly want to know about us here, as he had no connection with us."

(7) Bly: "It's funny, when I kind of got heated up, I felt he recognized the fact that I had made a step forward." Ingram leaned back in his chair, as though satisfied with the explanation that Dr.

\*A psychiatrist who had observed the group at the last meeting.

SUMMARIES AND INFERENCES

(8) *Veal was so authoritarian that he was afraid his "disobedience" in being late had humiliated Dr. N in the eyes of the visitor and therefore offered this apology (T).*

(9, 12) Bly tried twice to regain the center of attention by linking to Ingram. He was pointedly ignored by (10) Ingram and (13) Coombs.

OBSERVATIONS

N had given of the visitor's presence.

(8) Veal, speaking directly to Dr. N, explained that when he came in late last time, he wasn't aware that he was so late. He said his clock was slow. Ingram: "Getting back to the other subject, I wonder if we aren't being very gullible here?" Ingram went on to give an example of what had happened in school, the substance of which seemed to be that when the students were having a great deal of difficulty in working out a particular problem, they called for the teacher. When the problem seemed to be going well with the students, they resented the teacher's offering help. He continued, "When we have something wrong with us in here, we cry for you—yet when we take a step forward, it's hands off." Dr. N: "Can you go on?" Ingram, tense, blushing, looking down, continued: "I'm creating a state where everyday things seem to contribute to my ailment. I think I'm building up things bigger than they are."

(9) Bly: "We're all doing it, building it bigger than it is. I'm not talking about the physical, I'm talking about the mental." Ingram paid no attention to Bly.

(10) He continued, "Back to the point—the way the teacher made his point, we thought in his channel. Here, you're doing the same thing; you give it to us in your way and want us to ignore the



## SUMMARIES AND INFERENCES

(11) See (5).

(11a) See discussion of Coombs under Summary.

## OBSERVATIONS

rest of the world and to go right on doing things only your way." Ingram looked at the doctor as though expecting him to say something. Dr. N: "I have no comments." There was a short silence. (11) Dr. N to Ingram: "You feel as though I'm trying to put something over on you?" Ingram: "Yes—aren't you?" Coombs to Ingram: "Aren't you saying the same thing that Bly said—that your troubles are physical, not mental?" Ingram: "Yes." Coombs: "Why do you think it happened?" Ingram: "It's weakness." Coombs, referring to Ingram's feelings about the doctor: "He's got you under his thumb, and you don't know how he did it, or what to kick about?" Ingram: "Yes."

(11a) Coombs to Ingram, in a condescending manner: "At your age, I think it applies to someone in your family." Dr. N asked Ingram, "What is the feeling behind all this?" Ingram: "It's a feeling of weakness and lack of confidence." Dr. N repeated Ingram's statement and asked, "What else?" Ingram continued, "I don't want to get myself in that state again. In one way we are looking for help, and yet, at the same time, I'm trying to push you off. I think you're just going along with me, letting me tell you all this stuff, and you're going to use it against me. I have the feeling that you are holding things back and will use them against me when I least

SUMMARIES AND INFERENCES

(12) See (9).

(13) Coombs referred to feelings toward the doctor, expressed before joining this group (T).

(14) Coombs gained the focus for the first time during this meeting (the fourth he had attended) by presentation of a bizarre fantasy, (18) which cut him off from communication with the other patients.

OBSERVATIONS

expect it. People are very distrustful, you know." The doctor asked him what he thought made him distrustful. Ingram: "Mutual ties and bonds." Dr. N: "Could one reason be that you have to depend on people whom you distrust?"

(12) Bly broke in, "That strikes a chord with me. I strongly resent the fact that I have to take these pills to prevent dizziness."

(13) Coombs to Ingram: "I think that's very good—to fight against it (referring to the feeling of being dependent on those whom one distrusts). I share that with you." Coombs looked knowingly at the doctor. Castell looked intently at Coombs while the latter was speaking.

(14) Coombs: "There is something I want to say—but I don't know how to say it. It's all so vague—it has to do with my father—all the things I think of you (Dr. N) have to do with him. I can remember admiring him. On the question of fear of the doctor, I know that I fear my father, and I know that it's only him I fear. Last Wednesday I started getting the fear of you which I knew was fear of my father. Pieces of a dream I had before summer vacation began to come back to me, but it was of my mother and not my father—it was a feeling of castration." Coombs went on to tell of his feelings when he passed drugstore displays of rupture supports. He felt like buying one be-

## SUMMARIES AND INFERENCES

## OBSERVATIONS

cause of the pain in his genitals. He said that he woke up in the morning with his hands on his genitals and in great pain. The doctor acceptantly: "You find yourself hurting your genitals." Coombs: "In this dream the thing that my mother reached in the casket and pulled out was certainly an organ. I was wondering if this fear really isn't fear of myself that I might hurt myself." Coombs looked at the doctor as though expecting some comment. Dr. N: "This is so up in the air. . . ." Coombs continued, "When I went down to get this job, the doctor who examined me asked, 'Can you tell me whether you're sterile or not?'" He also told of an instance in which he cut his genitals in trying to climb a fence and there was some blood. He wouldn't tell anyone at home because he was afraid he would be punished. This was all connected with his feelings about his father. He told of memories of sitting and looking at his father with much admiration. Later in his life Coombs recognized that his father was really an abject figure. Dr. N: "What do you feel?" Coombs incoherently: "I don't know—getting walked over, as if I want to make a hero out of someone." Coombs was very much agitated, red in the face, sniffing and blowing his nose frequently, and Castell also sniffled, wiped his eyes, and blew

SUMMARIES AND INFERENCES

(15) Dr. N was trying to keep Coombs from being so disturbed by Castell's reaction and also to reassure Castell (T).

(16, 17, 19) Dr. N indicated his acceptance of and interest in Coombs (22) and his awareness that the fantasy baffled the group.

(18) See (14).

(19) See (16).

(20) *Evidence of Coombs' transference reaction. He saw his father as completely indifferent to him (T).*

OBSERVATIONS

his nose. Coombs asked if he were upsetting Castell.

(15) Dr. N said that Castell often became emotional in the face of others' emotions but was improving.

(16) Dr. N continued with Coombs: "Are there any feelings that you can connect with your feelings here about me?" Coombs: "The point is that it all goes back to my father—feelings of such great harm, such disaster." There was a short silence, disturbed by Castell's sniffles and Coombs' blowing his nose.

(17) Dr. N to Coombs: "The feelings seem to be mainly of being an outcast." Coombs, very excitedly: "Something antecedes this. Wasn't I born human? Why these fears? My father is dead. It's so hard to figure these things out because my memory of him in those later years is so clear."

(18) The other patients had been staring at Coombs, spellbound. Dr. N turned to the group and asked, "Does this make sense to anyone else here?" No one answered and there was a long silence.

(19) Dr. N turned again to Coombs: "All we can say is that your anger at the doctor is related to the fear of your father and thoughts of castrating yourself."

(20) Coombs: "Well, I felt that you weren't interested in what I said here—you didn't want me to open my mouth here."



## SUMMARIES AND INFERENCES

- (21) Dr. N was referring to Coombs' feeling, expressed in individual interviews, that his sister was favored by his parents (T).  
 (22) See (16).

(23) *Bly, still attempting to get the doctor's attention, tried the maneuver which Coombs had used successfully—that is, he presented a dream to parallel Coombs' fantasy.*

(24) Bly did not keep the doctor's attention.

## OBSERVATIONS

(21) Dr. N: "If you were a girl, if you didn't have genitals, then the doctor would give you the right to speak?"

(22) He then turned again to the group and commented that Mr. Coombs' fantasies were quite fantastic and that others might have difficulty understanding them.

(23) Bly said, "Speaking of dreams, I had a dream the other night; some men were trying to put something down, something heavy; it fell and crushed the box. I felt I was the box." The doctor repeated, "You were the box." Bly: "Yes, but I was also the person doing it." The doctor: "What were the thoughts?" Bly: "I have been waking up every morning about five o'clock, after a violent dream. This morning, it was about kids playing with a big pane of glass on a stairway—they let it fall and it hit a girl on the neck—the girl was standing beside me and I was trying to stop the blood. I called over to a fellow who was standing near by, one of the guys who works in my office, and told him to call a doctor. He was so excited that he couldn't do anything. I'm wondering if I was just picturing this guy as myself in order to bring him to my level." Ingram looked at the doctor as if requesting permission to speak.

(24) Dr. N nodded slightly. Ingram then turned to Coombs and said hesitantly, "I don't know your

SUMMARIES AND INFERENCES

(25) Bly attacked the member who had interrupted him and toward whom the doctor had been protective.

OBSERVATIONS

name," and looked at the doctor. Dr. N: "Coombs." Ingram continued, "Was your father reprimanding in any way?" Coombs: "My mother was." Ingram: "Well, last Wednesday you felt Dr. N was prejudiced against me and you took that as a reprimand and immediately thought of your father." Coombs told Ingram that this was not the case and that a look from the doctor would be more of a reprimand than any word. Dr. N to Ingram: "This arouses some thoughts?"

(25) Bly broke in, "I keep wondering why Ingram doesn't say what he has to say instead of saying it to Coombs. Of course, I'm angry with Ingram." The doctor repeated to Bly: "Angry with Ingram?" Bly: "Yes, I'm angry because Ingram broke in on me before I got any answer from you." Coombs: "Maybe you're angry with the doctor." Dr. N to Bly: "As I remember, I exchanged a look with Ingram before he began." Bly: "Anyway, I felt left out. I felt that he broke in before I finished." Dr. N: "There's a great deal of rivalry going on here." Bly: "Yes, but I didn't resent Coombs. I felt he was pertinent. I felt Ingram was just being general." Dr. N: "Is this anger at Ingram or at the doctor?" Bly: "I don't know—I felt I was really helping myself, and you let Ingram go on when he wasn't even being specific."

## SUMMARIES AND INFERENCES

(26) Dr. N summarized what appeared to be going on.

(26a) *Poorly timed question, as Bly was too disturbed to think about these relationships.*

(27) Although Ingram had long been hostile to Bly, he came to his defense when the doctor was unsympathetic to Bly and thus also expressed criticism of the doctor obliquely.

(28) Bly now made clear his anger at the doctor.

(28a) See discussion of Coombs under Summary.

## OBSERVATIONS

(26) Dr. N: "From the standpoint of the group here, Mr. Coombs brought up some fantastic material which got my attention and got Mr. Castell upset. Then you brought up some fantastic dreams, and you didn't get attention and then you turned on Ingram.

(26a) Does that compare with any incident in your family?" Bly did not answer this, and there was another silence.

(27) Dr. N turned to Ingram: "Do you agree with Bly?" Coombs asked Ingram: "What do you think was Bly's goal?" Ingram answered Coombs by saying, "He wants to state his problem. He wants someone to answer instead of having the subject changed abruptly." Dr. N to Ingram: "You think he feels small." Ingram: "Yes."

(28) Bly: "Now I'm really mad. You asked for a parallel, and I gave you one (referring to a parallel to Coombs' fantasy). Ingram is avoiding the point; I answered the question." Dr. N: "You had an answer ready for the doctor." Bly angrily: "Yes, you asked the question, didn't you?" Bly was ready to go on, but Dr. N continued, "Mr. Coombs has something to say." Coombs to Bly: "Ingram agreed with you." Bly: "I didn't mind him agreeing."

(28a) Coombs: "While he was talking to you, he was trying to explain something to me. Why

SUMMARIES AND INFERENCES

(29) The doctor abruptly tried to examine Ingram's feelings with him as a way of supporting him, knowing that he tended to exaggerate his responsibility for upsetting others (T). This being contrary to the group preoccupation with their anger, the group refused to permit it and continued expressing hostility.

(30) Veal attacked Dr. N. See also (34).

(31) Bly attacked Ingram (33) and Dr. N.

(32) Coombs attacked Bly.

(33) See (31).

(34) *Veal could attack the doctor only with very strong group sup-*

OBSERVATIONS

were you concerned?" Bly said he didn't know.

(29) Dr. N: "This has got Mr. Ingram on the spot." Ingram smiled and blushed in embarrassment. Dr. N: "I think we can learn a great deal about ourselves from things of this kind." He turned to Ingram: "What are you feeling?" Ingram: "Guilty because I have upset them."

(30) Veal to Dr. N: "It seems to me you tell us what to do, then ignore us. . . ."

(31) Bly: "The thing I get mad with . . . uh. . . ." He blocked on Ingram's name and laughed, "I even refuse to recognize his name." He continued, "I thought that was a set up—I thought."

(32) Coombs interrupted Bly to say to Veal: "When you paused there, were you through?" Veal said that he was just about through. Coombs continued, "I thought he was just pausing for breath and Bly pops in." Dr. N: "So you felt Veal was also waiting for a comment from the doctor when Bly interrupted. Again you expect the doctor to be the one who gives advice." Bly: "Isn't that normal?" Dr. N: "Well, let's look at it. In a way the doctor is generally recognized as advice-giving. Is that sensible?"

(33) Bly: "If we were sensible, would we be here?"

(34) Veal intellectually supported the view that the doctor is the



## SUMMARIES AND INFERENCES

port. He had never before directly expressed hostile feelings in the group and never before linked himself to the other group members as "we."

(35) *This speech clearly reflects Bly's confusion over dependence and independence.*

## OBSERVATIONS

logical one to give advice: "Here we might have the tendency to end up in arguments, but we can consult you and get the right answer. Otherwise, we might end up angry at each other." Dr. N: "Anyone else?" Ingram: "Your knowledge of the subject should make you the one better able to cope with it." Coombs to Ingram: "If he did that, you would be in a worse spot than you are now. You've said already that you felt bad, that you're under his thumb now. It seems to me his job is to try to find out why we don't know the answers for ourselves and to help us to find them." Ingram: "I'm inclined to put him on a pedestal." Coombs to Ingram: "That would make it worse for you in the end, wouldn't it?" Ingram agreed with Coombs. After reflective questions from the doctor, Bly spoke up.

(35) Bly: "Well, I wish you would stop treating us like children. If you would come out and lay the facts on the table and let us look at them, that would help us. You have all the facts and all the records and we have nothing. We're men, after all. I don't want to be a child again, and I don't want to be treated like one. With your knowledge and background you'd know what's important. I have the feeling that you deliberately stay out so that we will have to do it all."

SUMMARIES AND INFERENCES

(36) The doctor failed to make this point clear in his effort to include other members in the discussion.

(37) See (38).

(38) When Dr. N focused on Veal, (39) the latter withdrew *because he feared that (37) his implied criticism had angered the doctor. This was in keeping with (8) his need to submit to authority.*

OBSERVATIONS

(36) Dr. N: "It seems to me the idea is that the doctor has knowledge and refuses to give it (referring to Bly) or else he uses his knowledge against them (referring to Ingram)."

(37) Veal: "I wonder if you gave direct answers like other doctors, wouldn't that make them angry with you, just as they are with other doctors?"

(38) Dr. N to Veal: "What would be the reason for the doctor's giving the answers indirectly and letting the patients guess the answers? What would keep the doctor from giving the answers in the first place?" Veal: "Nothing, if you wanted to." He repeated that he thought a direct answer would give patients no help and end up with their being angry. Dr. N: "If the doctor gave a direct answer, they would be angry—so the only way not to have them angry at him is to be indirect?"

(39) What the doctor said, Veal went on to explain, was not exactly the way he had meant it.

Dr. N: "There is something in common in the attitudes of Ingram, Bly, and Veal. Bly believes that the doctor could give information and won't. Ingram seems to believe that the doctor is putting something over on him. Veal sees the doctor in the role of a kindly parent who is trying to wait for the child to see for himself and thereby learn."

## SUMMARY OF THE MEETING BASED ON THE DISCUSSION BETWEEN THE DOCTOR AND THE OBSERVER

### *The Doctor's Reactions and Goals*

Dr. N thought that the meeting had been a good one and that his goal of facilitating examination of hostile feelings toward himself had been largely achieved. The patients' examination of their attitudes toward the doctor was the best that this group had shown (11, 19, 20, 28, 30, 34, 35). Bly's examination of his feelings toward the doctor (35), which followed from his unsuccessful attempt to get the doctor's attention by using the same means that Coombs had used (23), was especially important. This also brought out the rivalry between Bly and Ingram, expressed overtly by Bly and covertly by Ingram in that he ignored Bly's interruptions.

### *Group Dynamics*

In the previous meeting doubts had been expressed as to the value of psychotherapy; there had been several tense silences, and Coombs had attacked Bly for continually linking himself to Ingram on the basis of what Coombs felt were spurious similarities. When the doctor seemed to agree with Coombs, Bly expressed some anger toward the doctor. In this meeting member-to-member and member-to-doctor hostilities were more open and the patients were able to tolerate and examine them. Bly was the object of hostility from Coombs (32) and Ingram (10, 24).

### *The Doctor's Interventions*

Dr. N was more directive than usual. His initial choice of topic, his holding the group to it (1, 2, 3), and his later examination of the group process (26) were determined by his desire to facilitate expression of hostility to himself, in order to help the patients discover the real source of their anger. However, so many issues arose that he had to pass over some of them, including: (a) Bly's feeling that no doctor believed him, (b) Bly's resentment at being "treated like a child" (the doctor was not able to take up with him the fact that this was the only type of relationship Bly permitted) and (c) Veal's ignoring the rest of the group when he apologized to the doctor about being late for the previous meeting.

*Behavior and Psychodynamics of Individual Patients*

Bly's attempts to get Dr. N's attention by spuriously linking with others (7, 9, 12, 23) were rebuffed by patients and doctor (10, 13, 24), leading him to express displaced hostility toward a patient (25, 31) and direct hostility toward the doctor (28, 33). The value of this to him was unclear at this point. He saw Dr. N as treating him like a child by deliberately withholding information which would cure him (35). Dr. N chose not to take up with him the contradiction implied in this and not to point out that Bly had put himself in the position of a child. Bly saw Ingram as a rival for Dr. N's attention (25). (The doctor thought it was interesting to note that Bly associated rage with the fact that for the first time in the group he had felt independence and self-respect.) Another point which Dr. N brought out was that he had given Ingram a permissive look before Ingram cut off Bly, but that Bly had seemed to ignore this and to direct his wrath solely at Ingram.

Castell's emotional reaction to Coombs' display of feeling was similar to what he usually showed (15). His silent participation was characteristic.

Coombs was attending Dr. N's Group II for the fourth time. The doctor subsequently remembered that in the early meetings of Coombs' previous group, he had similarly shocked and confused the other members by presenting bizarre fantasies (14) as a way of compelling their attention. The doctor accepted it, not wishing to add a further rebuff to his recent termination of individual treatment (for administrative reasons). Coombs' patronizingly protective attitude toward Ingram, eight years his junior and obviously the youngest member of the group (11a) seemed to the doctor to be related to Coombs' attitude toward his own much younger brother (13), whom he despised. He also tried to defend Veal against Bly (32), whom he attacked openly (28a). It was unclear why Bly had irritated him so much. Dr. N speculated that Coombs saw himself as appeasing the doctor in order to forestall his wrath. He had not called Coombs to account for this maneuver because he felt that it might be too upsetting for the patient.

Ingram, after expressing his suspicion of last week's visiting doctor (5), was able to express his distrust of Dr. N (11). He still was unable to express his anger at Bly but revealed it covertly by pointedly ignoring Bly's interruption (10), and by indicating interest in Coombs (24) who openly attacked Bly.

Veal was enabled by the group atmosphere of hostility toward Dr. N



to express for the first time his annoyance at the doctor's failure to give advice (30). He believed that Dr. N should give the "right answers" to forestall arguments and prevent patients' getting angry with each other (34), but he also felt that if Dr. N did this, the patients might become angry with him (37). That is, authority must be exercised indirectly so as not to incur hostility from subordinates. When the doctor attempted to reflect these feelings, Veal backed away from examining them. This was the nearest he had come to revealing anything about his feelings.

## APPENDIX B

### *The Completeness and Accuracy of the Running Account\**

---

THE validity of any research finding is determined by the extent to which it enables one to make accurate predictions. In view of this fact, it would appear obvious that sparseness and distortion of the raw data of an investigation may seriously affect the scope and correctness of inferences and hypotheses that are drawn from them; yet even a plethora of data provides no insurance against inaccurate predictions,<sup>†</sup> since the skill of the researcher to grasp relationships and to conceptualize them remains a crucial variable. In attempting to evaluate completeness and accuracy of the running accounts which constitute the principal data of our study, it was therefore of fundamental importance to establish the soundness of our basic assumption that the trained observer is capable of reporting, with a minimum of distortion, the essential phenomena of group meetings. In this assumption, which was in essential agreement with that of all psychotherapists who choose to make notes and summaries of treatment sessions rather than complete transcripts, three questions remained implicit:

1. How much of what is actually said in a meeting is reported by a trained observer?
2. How accurately are such data reported?
  - a. How much of what is actually said in a meeting is reported
    - (1) with no distortion?
    - (2) with slight distortion?
    - (3) with great distortion?
  - b. Of what an observer selects to report (i.e., his total record of the meeting) how much does he report
    - (1) with no distortion?

\*Major contributors: Helen T. Nash and Morris B. Parloff.

†This has been well illustrated by Kelly and Fiske,<sup>1</sup> who found that the accuracy of the researcher's predictions diminished as the data made available to him increased.

(2) with slight distortion?

(3) with great distortion?

3. How reliably do two trained observers report the same meeting?

a. What proportion of what each reports is in complete agreement, in partial agreement, in clear disagreement?

In order to answer these questions we selected 28 running accounts for analysis. These were drawn from 10 different therapy groups composed of psychoneurotic patients treated at the Washington Mental Hygiene Clinic.\* Two bases of analysis were adopted: (1) comparison of observers' accounts with wire transcripts to determine the completeness and accuracy of the former, and (2) comparison of pairs of observers' accounts with each other to determine the extent to which items were mutually or independently reported.

The running accounts used in the test were written by staff members regularly assigned to group observation in the over-all research project. Although observers routinely attempted to record both the verbal and non-verbal content of the group meetings, only verbal content was considered in our analysis. This limitation was imposed by the fact that the wire transcripts against which we checked the observers' accounts were of course limited to audible communication.

#### ITEM ANALYSIS OF OBSERVERS' ACCOUNTS AND WIRE TRANSCRIPTS

The typical group meeting lasted approximately 90 minutes. To facilitate comparison with the running accounts selected for study, transcriptions were made of three 5-minute samples of each wire-recording. It was planned that these periods should cover the 5th to 10th minutes, the 30th to 35th minutes, and the 60th to 65th minutes of the meetings. In practice, however, it was not possible to adhere strictly to our plan, since much of the wire-recording was not clear enough to be transcribed. The 5-minute periods actually transcribed fell between the 5th and 15th minutes, the 30th and 50th minutes, and the 60th and 75th minutes.

In each case corresponding portions of the observer's account and the wire transcript were categorized by items, which were then ar-

\* Attempts to obtain wire recordings of group meetings of hospitalized schizophrenics met with failure. Patients would not speak loudly enough, spoke from distant corners of the room, remained silent, became disturbed by the machine, or actually turned the machine off. One threatened to destroy it. However, it was felt that the advantage of treated observers was especially apparent with schizophrenic groups, since non-verbal communication constituted such a large part of intra group phenomena.

ranged in parallel columns. The items from the wire transcript were numbered consecutively, those from the observer's account were **lettered consecutively**.

An item was defined as that portion of an observer's account or the wire transcript (a phrase, a sentence, or a combination of sentences) which contained a single idea or attitude. Identification of items in both the observer's account and the wire transcript required the agreement of two judges. Examples of items are listed below.

- (1) Doctor: "Two days ago you said I hated you."
- (2) Patient: "I've always felt that. I think I've always felt you hated me."
- (3) Doctor: "How was I manifesting my hate?"
- (4) Patient: "I told you how you did it."

A longer speech was itemized as follows: (1) "You mentioned before that you are concerned about your eyes and about poking your finger into your eye . . . not being able to look at things for a long while. . . ." (2) "That raises the question of whether you saw something forbidden . . . or fear that you're going to see something forbidden. . . ."

### **Completeness**

The completeness of an observer's account was measured by noting the proportion of items in the wire transcript that he had reported.

If the speaker repeated himself in the course of a single speech (as indicated by the wire recording), the original statement and the repetition were considered to be one item. For example:

<i>Wire Transcript</i>	<i>Observer's Account</i>
(1) Lyon: "I have a tendency to distrust people, and I am always <b>on the alert and never trust any one or believe in them.</b> "	a. Lyon said he is distrustful of people.

If the speaker repeated himself after a complete change of subject the repetition was treated as a new item. For example:

<i>Wire Transcript</i>	<i>Observer's Account</i>
1. Thomas: "I can't stand my father. I can't even stay in the same room with him."	a. Thomas said he hated his father and couldn't bear being in the same room.
2. Lyon: "I don't like my mother."	b. Lyon stated he disliked his mother.



*Wire Transcript*

(3) Steel: "Well, I don't like my in-laws."

A 5-minute discussion of in-laws followed, but Thomas returned to his statement with:

(10) Thomas: "Well, I can't even stay in the same room with my father."

*Observer's Account*

(c) Steel interjected he disliked his in-laws.

(h) Thomas repeated that he disliked being with his father.

This repetition of (a) after a change of subject indicates an intensity of feeling which could be conveyed only by reporting both items.

If the original meaning of an item in the wire transcript was altered by any of the speaker's subsequent statements, the change had to be noted by the observer. Otherwise an omission was scored. Sections of the observer's account corresponding to unintelligible parts of the wire transcript were omitted.

*Accuracy*

Accuracy was measured by the proportion of undistorted items in the observer's running account (i.e., the percentage of items which conveyed a meaning identical with that of the wire transcript). The meaning of any item was considered to be established when it was agreed upon by the two impartial judges assigned to this part of the analysis. (These judges attempted to determine only manifest meanings, not implicit meanings.) Observers' items were scored as undistorted when the judges agreed that the meaning conveyed was the same as that contained in the wire transcript, even though the observer might have omitted or altered words, phrases, or sentences. Observers' items were scored as undistorted, slightly distorted, or greatly distorted by the following standards: An item was rated as slightly distorted if the meaning conveyed was correct although somewhat modified. An item was classed as greatly distorted if there was a contradiction or other radical alteration of meaning or if no corresponding item was found in the wire transcript. (However, in such cases a careful review of the wire transcript frequently revealed the basis for the observer's entry.) Inspection showed that the main ways in which items were distorted were incompleteness, addition, or alteration, as illustrated in the examples given below.

## UNDISTORTED

*Wire Transcript*

- (1) Thomas (to Eubank): "That sounds like poor rationalization when you can't get an appointment and then say, 'Well, I'll have a day of rest.'"
- (2) Doctor: "Apparently you are carrying that pattern over to the treatment situation."

*Observer's Account*

- (a) Thomas said that Eubank sounded as if he were rationalizing when he said it was a "day of rest" when he couldn't get an appointment.
- (b) The doctor suggested to Eubank that there was a parallel in the treatment situation.

## SLIGHTLY DISTORTED

*Wire Transcript*

- (1) Smith: "I didn't say that.
- (2) I don't think anyone else here thinks I said that. You're making that up out of whole cloth, Mr. Jones."

*Observer's Account**By Incompletion (Omission of Detail)*

- (a) Smith claimed he was misquoted. (Although what is reported is correct, Smith's attitude toward Jones and others in the group is not indicated by the observer's brief summary statement.)

*By Addition*

- (1) Saunders: "I've been with people I've grown to dislike for some reason or other."

- (a) Saunders talked about being with some people he *grows to like* and some whom he grows to dislike.

(The thought conveyed by the italicized phrase is not found in the original statement.)

*By Alteration*

- (2) Merrill (in answer to the doctor's question whether Merrill was more comfortable when the group was smaller): "The way I was feeling last week-end I don't think it matters whether there were all ten guys. . . ."

- (a) Merrill said he felt last week that all humanity could have been here.

## CREATLY DISTORTED

*Wire Transcript**Observer's Account**By Incompletion*

- (1) "Running through my mind was, 'He has a face that only a mother could love.' And I know as a kid I must have heard that one about my position—'That poor bastard, only a mother could love him.'"
- (a) The patient mentioned the phrase, "Only a mother could love you."

*By Addition*

- (2) Doctor: "Sex is one of our biggest forms of guilt."
- (b) The doctor agreed that most neuroses are connected with sex because it's the most hushed up.

*By Alteration*

- (3) "I didn't find it necessary to go into detail with Mr. G and I've been keeping some information from you."
- (c) He hesitated to go into detail with Mr. G but said, "With you, doctor, I feel I can say what I want."

If the observer omitted an item entirely, no attempt was made to evaluate the distorting effect on the meaning of subsequent items. But if he reported part of an item, both parts were carefully examined to determine whether the effect of the omitted part altered the meaning of the observer's account so as to require classification as greatly or slightly distorted.

#### ITEM ANALYSIS OF ACCOUNTS BY PAIRS OF OBSERVERS

Only one observer was regularly assigned to a group. But when we attempted to test the agreement between two observers in reporting the same meeting, we decided to compare a "familiar" observer (i.e., one who was the regular observer of the group) with an "unfamiliar" observer (i.e., one who had never previously observed the particular group on which he was asked to report for purposes of this analysis). The alternatives would have been (1) to familiarize a second observer with the group or (2) to use two equally "unfamiliar" observers. The first plan was rejected as unfeasible, since this would have interfered with the observers' routine duties. The second alternative would have failed to provide us with a measure of the performance of the familiar

TABLE 27. Proportion of Wire-Transcript Items Reported by Observers

<i>Number of observers</i>	<i>Number of wire-trans- script items</i>	<i>Number of items reported</i>	<i>Percentage of items reported</i>	<i>Range of percentages</i>
Familiar	4	360	52*	38-59
Unfamiliar	8	1,000	45*	37-53
All	12	1,360	47	37-59

\*Mean difference between percentages of items reported by familiar and unfamiliar observers not significant.

$t = 1.448$ , with 10 degrees of freedom;  $P$  is greater than .10.<sup>2</sup>

observers, who after all furnished the data which were actually used in the over-all research.

### *Independent and Mutual Items*

The accounts of each pair of observers were categorized into items, and the items were then lettered consecutively and listed in parallel columns. Items that were reported by one observer but not by his partner were called "independent." Those which both observers had reported in such a way that the items could be matched, regardless of whether they were accurate or distorted in one or both accounts, were called "mutual." After computing the percentages of independent and mutual items in each observer's account, we then computed the percentages of each observer's mutual items that were in complete agreement with those of his partner, in partial (or unclear) agreement, and in complete disagreement. The evaluations on which these computations were based were arrived at by consensus of two impartial judges.

## FINDINGS

### *Completeness*

How much of what is actually said in a meeting is reported by a trained observer? To answer this question wire-transcript samples were itemized and compared with corresponding sections from 12 reports (4 by familiar observers and 8 by unfamiliar observers). The findings were as follows: familiar observers reported 52 per cent of 360 items on wire-transcript samples and unfamiliar observers reported 45 per cent of 1,000; the average reported by all observers was 47 per cent (see Table 27). The mean difference between the per cent of items reported by familiar and unfamiliar observers is not significant.

### *Accuracy*

How much of what is actually said in the meeting does the observer report (1) with no distortion, (2) with slight distortion, or (3) with

great distortion? To answer this question wire-transcript samples were itemized and compared with corresponding sections from 12 reports (4 by familiar observers and 8 by unfamiliar observers). The data revealed that of 360 items on wire-transcript samples, familiar observers reported 42 per cent with no distortion, 9 per cent with slight distortion, and 1 per cent with great distortion; of 1,000 items unfamiliar observers reported approximately 32 per cent with no distortion, 12 per cent with slight distortion, and 2 per cent with great distortion; and all observers reported approximately 34 per cent with no distortion, 11 per cent with slight distortion, and 1 per cent with great distortion (see Table 28). The mean difference between the proportion of undistorted items reported by familiar and unfamiliar observers is found to be significant at the 2 per cent level of confidence ( $t=2.773$ , with 10 degrees of freedom), but the differences between familiar and unfamiliar observers in reporting "slightly" and "greatly" distorted items do not exceed chance expectation. These findings indicate that familiar observers do not report significantly more of a meeting than unfamiliar observers but do report it more accurately.

Of what an observer selects to report, how much does he report (1) with no distortion, (2) with slight distortion, and (3) with great distortion? To answer this question the items reported by each observer were rated for degrees of accuracy. Of the 187 items reported by familiar observers it was found that 81 per cent were not distorted whereas of the 450 items reported by unfamiliar observers 71 per cent were not distorted (see Table 29). This difference between the familiar and unfamiliar observers is found to be significant beyond the 5 per cent level of confidence ( $t=2.597$ , with 10 degrees of freedom). The differences in occurrence of "slightly" and "greatly" distorted items in the reports of familiar and unfamiliar observers could, however, be due to chance.

How reliably do trained observers report the same meeting? In order to determine the extent to which two trained observers would select and report the same items if they observed the same meeting, we analyzed the complete reports of 8 pairs of observers, which provided a total of 16 records (1 pair of records for 1 meeting from each of 8 different groups). These records were itemized and the appropriate pairs were compared to determine the mutuality of reporting. It was found that of the total number of 3,451 items in the reports of all observers, 2,148 (62 per cent) were reported mutually, that is, by both members of a pair of observers, and 1,303 (38 per cent) were reported independently (see Table 30).



TABLE 28. Proportions of Wire-Transcript Items Reported by Observers with Varying Degrees of Accuracy

NUMBER OF OBSERVERS	NUMBER OF NUMBER WIRE-TRAN- OF SCRIPT ITEMS REPORTED			UNDISTORTED			SLIGHTLY DISTORTED			GREATLY DISTORTED		
	NUMBER OF OBSERVERS	WIRE-TRAN- SCRIPT ITEMS REPORTED	OF ITEMS REPORTED	Number	Per cent	Range of percent- ages	Number	Per cent	Range of percent- ages	Number	Per cent	Range of percent- ages
Familiar	4	360°	187°	150	42†	34-46	33	9	3-14	4	1	0-1
Unfamiliar	8	1,000°	450°	318	32†	22-40	116	12	7-21	16	2	0-4
All	12	1,360°	637°	468	34	22-46	149	11	3-21	20	1	0-4

\*See Table 27.

†Mean difference between familiar and unfamiliar observers is significant at the 2 per cent level of confidence ( $t=2.773$ , with 10 degrees of freedom).

TABLE 29. Proportions of Observers' Items Reported with Varying Degrees of Accuracy

NUMBER OF OBSERVERS	NUMBER OF ITEMS REPORTED			UNDISTORTED			SLIGHTLY DISTORTED			GREATLY DISTORTED		
	NUMBER OF OBSERVERS	WIRE-TRAN- SCRIPT ITEMS REPORTED	OF ITEMS REPORTED	Number	Per cent	Range of percent- ages	Number	Per cent	Range of percent- ages	Number	Per cent	Range of percent- ages
Familiar	4	187°	150†	150†	81°°	77-89	33†	17	7-23	4†	2	0-4
Unfamiliar	8	450°	318†	318†	71°°	59-83	116†	26	15-39	16†	3	0-10
All	12	637°	468†	468†	73	59-89	149†	23	7-39	20†	3	0-10

\*See Table 27.

†See Table 28.

°°Mean difference between familiar and unfamiliar observers is significant at the 5 per cent level of confidence ( $t=2.597$ , with 10 degrees of freedom).

TABLE 30. Independent and Mutual Reporting of Meetings by 8 Pairs of Observers

<i>Paired observers</i>	<i>Number of items reported</i>	<i>Number of items in- dependently reported</i>	<i>Percentage of items indepen- dently reported</i>	<i>Number of items mutually reported</i>	<i>Percentage of items mutually reported</i>
A	262	67	26	195	74
B	257	62	24	195	76
A	191	48	25	143	75
B	216	73	34	143	66
A	230	67	29	163	71
D	273	110	40	163	60
C	182	69	38	113	62
D	233	120	51	113	49
B	218	105	48	113	52
C	205	92	45	113	55
B	233	127	55	106	45
C	162	56	35	106	65
A	195	85	44	110	56
C	163	53	33	110	67
A	233	102	44	131	56
C	198	67	34	131	66
Total	3,451	1,303	Av. 38	2,148	Av. 62
Total for first observer of each pair	1,744	670		1,074	
Total for second observer of each pair	1,707	633		1,074	

If we add the items reported by the first observers of each of the 8 pairs described in Table 30 we find that the total is 1,744. If the selection of items had been dictated by chance alone we should expect 820 of these items (47 per cent) to be mutual items and 924 to be independent items. We find, however, that 1,074 (62 per cent) were mutual items and 670 (38 per cent) were independent items. Similarly, 1,074 (63 per cent) of the total 1,707 items in the second observers' reports were mutual items. When we test this deviation from chance expectancy we obtain a Chi square of 148.5. With 1 degree of freedom the probability that this difference will occur by chance is less than once in 1,000.

TABLE 31. Extent of Agreement between Paired Observers on Items Mutually Reported

PAIRED OBSERVERS	NUMBER OF ITEMS MUTUALLY REPORTED	COMPLETE AGREEMENT		PARTIAL AGREEMENT		DISAGREEMENT	
		Number	Per cent	Number	Per cent	Number	Per cent
B	44	31	70	13	30	0	0
A	44	32	73	12	27	0	0
A	39	34	87	5	13	0	0
B	39	30	77	6	15	3	8
A	35	21	60	12	34	2	6
C	35	25	71	8	23	2	6
D	18	12	67	6	33	0	0
C	18	9	50	9	50	0	0
Total	272	194	71	71	26	7	3

What proportion of mutually reported items are in complete agreement, in partial agreement, and in clear disagreement? Using 8 samples of the 16 records described above, a total of 272 mutually reported items were analyzed to determine the extent to which each such item in an observer's report agreed with that of his partner. A summary of the findings is presented in Table 31. It was found that of the 272 mutually reported items, 194 (71 per cent) were in complete agreement, 71 (26 per cent) were in partial agreement, and 7 (3 per cent) were in clear disagreement.

### Discussion

In terms of the units which we have defined as "items" our observers' accounts contained slightly less than half (average, 47 per cent) of what was verbalized in the group meetings. Previous knowledge of a group tended to increase the amount which an observer could record as compared with that which an unfamiliar observer could record, but the difference was not statistically significant. This implies that the trained observer records a fairly constant proportion of the content of a group meeting, regardless of his previous experience with a particular group. Two alternative explanations suggest themselves to account for these findings:

1. Observers may have attempted to record everything that was verbalized, but since they were working without mechanical aids, they may have been handicapped by the physical tasks of observing, listening, and recording. Hence the 47 per cent average given above

may represent maximum reporting capacity rather than deliberate selection of data.

2. There may have been tacit agreement among observers on the type of data that were sufficiently relevant to the study to be recorded, and such data may have covered approximately half of the content of the meetings.

If the first explanation were solely operative, then comparison of observers' reports would not show mutuality of reporting beyond chance expectancy, but if mutuality were found to exceed chance, then the second explanation—tacit agreement in reporting—would probably be operative. This was clearly the case, since the proportion of mutual items (over 60 per cent of all observers' items) could have occurred by chance less than once in 1,000 cases. (We are assuming, on the basis of examination of the data and interviews with the observers, that the difficulty of reporting remained relatively constant in the samples tested. The possibility that mutuality of reporting may be due to the fact that certain periods were easier to record than others and that both observers recorded these more fully is tentatively rejected.) Although familiar and unfamiliar observers who reported the same meetings thus duplicated each other's accounts to a significant degree (over 60 per cent of all reported items), the familiar observers tended to report more accurately (81 per cent of their reported items) than the unfamiliar observers (71 per cent of their reported items).

On the basis of Tables 27-29 we may conclude that the running accounts used in the over-all research, which were routinely prepared by familiar observers, included 52 per cent of what was said in the group meetings—42 per cent being completely accurate, 9 per cent slightly distorted, and 1 per cent greatly distorted. It would seem, too, that of what these familiar observers reported 81 per cent was undistorted, 17 per cent was slightly distorted, and 2 per cent was greatly distorted.

In the design of our investigation we agreed to err in the direction of minimizing rather than maximizing the adequacy of our observers. We have therefore excluded from consideration three factors which in practice tend to enhance the completeness and accuracy of reporting a group meeting.

1. Much of the verbal content of a meeting is repeated in the course of therapy. The same patients periodically relate the same symptoms and complaints and offer the same formulations.
2. As the functioning of the patient becomes clear, his behavior becomes more meaningful and therefore easier to record.

3. As the patterns of group relationships are defined, previously obscure remarks become more intelligible.

Furthermore, the average amount of agreement in the mutual choice of items (62 per cent of all reported items) may underestimate the extent to which observers agreed. Analysis of a report by items is an atomistic method which may be compared to the analysis of a line segment by points. Independent researchers may each select different points and yet be able to plot identical lines. In the same manner two observers may select different items and yet be able to plot identical lines of thought. Although their actual agreement in items may have been zero, they may have succeeded equally well in conveying an accurate description of the event to the reader. In order to check the extent to which the observers' reports actually conveyed similar meanings we devised another means of analyzing them based on a molar unit, the topic.

#### TOPIC ANALYSIS BY PAIRS OF OBSERVERS

Topic analysis was devised as a simple, rapid way of determining the extent to which the reports of two observers agreed along more general lines than item-reporting. This scheme was not intended to constitute a method of studying the processes of therapy but was designed primarily to permit direct comparison of records in terms of selected variables which experience suggested were relevant to therapy and which could be observed with a minimum of inference. Concurrence between two observers' reports was studied in regard to:

1. The issues being discussed—divided into topics and sub-topics.
2. Who joins in the discussion—initiator, protagonist, and others.
3. To whom or to what the participants refer in discussing the issue—themselves, other members of the group, or other referents.

This analysis was done jointly by two judges: one who was familiar with the reports on several groups and one who had previously observed the group in question. No judge studied his own report. Complete running accounts of the same meeting made by two observers were compared. A sufficient time interval was allowed to pass between the analysis of each of a pair of reports to minimize the carry-over of ideas from one to the other.

A sheet of paper was divided into seven columns. In the two left-hand columns the topics and sub-topics were briefly summarized. The initials of the patients who discussed the topic were placed in the appropriate columns (see Table 32). The following categories were used:



### *Issues around Which the Interactions Occur*

*The topic.* Issues, or subjects, under discussion were called topics. Any definite shift in subject was considered to introduce a new topic, even though there was a return to the former topic. The topic might or might not form a unit with the question which introduced it. What constituted a topic was determined by the two judges.

*The sub-topic.* Different aspects of the same topic were classified as sub-topics. Since the main purpose of the analysis was to determine whether two observers reported essentially the same developments, topics were changed from topics into sub-topics if this increased agreement between two accounts.

*The item.* See definition under item analysis.

For example, in the comparison of the reports of Observers A and B given in Table 32 the judges classified Observer A's topic as "size of group" (with 2 sub-topics) and Observer B's topic as "number of members preferred in group" (with 3 sub-topics). As the judges agreed that the topics were essentially the same, Observer A was scored 67 per cent and Observer B 100 per cent on agreement. In Table 33 these observers had a score of 31 per cent for complete agreement on items.

*Omissions.* Questions which were stated but not discussed and subjects which were introduced but not discussed were not classed as topics.

### *The Persons Who Discussed a Given Topic*

*The initiator* was the one who introduced the topic, either by a direct reference or by a question. His initial was entered under the proper column. In the sample record in Table 33, as both observers reported that S introduced the topic, each was scored 100 per cent on agreement.

*The protagonist* was the member of the group whose problem was being discussed. If the discussion had no reference to an individual, this column was left blank. Usually there was only one protagonist, but sometimes there were several. In the sample record both observers reported that S was the protagonist, and again each was scored 100 per cent on agreement.

### *References of Discussants*

*Reference to self.* When the speaker related the topic to himself or to people or events in his own life, without directly referring to other group members, his initial was placed in the column headed *Self*. In the sample record, as both observers indicated that S spoke

about himself, his initial was placed in this column. As Observer A reported that G also spoke about himself, this was noted in the proper column of A's analysis. (The agreement scores were 100 per cent for A and 50 per cent for B.)

*Reference to others.* When the speaker made a reference to others in the group or to persons not part of his own experience, his initial was entered in the column headed *Others*. In the sample record, as both observers reported that S and the doctor referred to some other person in the group, the two initials were listed in this column and each observer was scored 100 per cent on agreement.

*Reference to rest (impersonal or unclear).* When the speaker referred to something general or impersonal, or the object of his reference was obscure, his initial was entered in the column headed *Rest*. No matter how many times a speaker referred to himself, to others, or to generalities, with respect to a given topic, his initial was entered only once for that topic in any one column.

### *Procedure*

The following sample records illustrate the procedure we followed for comparing the running accounts of a pair of observers. They cover the first 5 minutes of the same group meeting. The account of each observer is considered to be a single *topic*. (No *sub-topics* are indicated.) The remarks separated by letters in parentheses are considered to be *items* and are lettered consecutively in each report, without regard to corresponding items in the other report. (In the complete running accounts there were, of course, many more topics and items—approximately 20 of the former and 200 of the latter for each record.) A statistical analysis of this brief sample is given in Tables 32 and 33.

#### SAMPLE RECORDS

##### *Report of Observer A*

###### (Topic 1)

- (a) S began by asking about M.
- (b) Dr. D said M had left.
- (c) S asked, rather anxiously, "Has anyone else dropped out?"
- (d) Dr. D looked uninterested in all this, then, smiling, asked S what he wanted.
- (e) S said he'd like more people or fewer people in the group.

##### *Report of Observer B*

###### (Topic 1)

- Meeting began about 1:10, patients filing in in a desultory manner.
- (a) S questioned doctor about M—whether he is returning to the group.
- (b) Doctor asked, "What are you working on, Mr. S?"
- (c) S then began to complain that

*Report of Observer A*

- (f) G: "That's a problem in itself, I guess."  
 (g) S said they get different views with four or five people in the group.  
 (h) Dr. D reminded him that sometimes they were down to a group of two—"just you and I."  
 (i) Dr. D thought S and "all his problems" were here, no matter who else is here.  
 (j) S said sharply that he could sit in a room and talk to himself.  
 (k) Dr. D: "Is Mr. G somewhat of a handicap?"  
 (l) S seemed to be talking anxiously and evasively, in answer to the last question, saying that he thought the idea was, that the more people. . . .  
 (m) G: "I don't look at it that way." Silence.

*Report of Observer B*

- a two-hour conference is quite difficult, with only two or three people present.  
 (d) He prefers four or five, then he can get views from others.  
 (e) Doctor: "That brings up individual sessions, where it is just you and I."  
 (f) S said whiningly that sometimes the doctor just coaxes him through the hour.  
 (g) Doctor: "You and all your problems are here whether others are here or not."  
 (h) He said that S could talk to himself for an hour.  
 (i) S thought the main purpose of the group was to talk with other people.  
 (j) S can't talk for two hours.  
 (k) He said he is pretty sure Mr. G can't either.  
 (l) G commented inaudibly.  
 (m) Both laughed and a long silence followed.

*Agreement Scores*

The average agreement scores of 5 pairs of observers with respect to the variables were as follows:

1. Topic	88 per cent
2. Sub-topic	82 per cent
3. Initiator	73 per cent
4. Protagonist	82 per cent
5. Reference to self	83 per cent
6. Reference to others	80 per cent
7. Reference to rest	71 per cent

*Discussion*

As demonstrated above, topic analysis offers a simple and relatively easy method of scanning group records for data pertaining to certain

TABLE 32. Agreement in Sample Records, by Topic Analysis

	<i>Topic</i>	<i>Sub-topic</i>	<i>Initiator</i>	<i>Protago- nist</i>	<i>Self</i>	<i>Others</i>	<i>Rest</i>
OBSERVER A	1. Size of group	1. Absentees 2. Different views with larger group	S	S	S  G	S  Dr.	G
Agreement with partner		67%*	100%	100%	100%	100%	100%
OBSERVER B	1. Number of members preferred in group	1. Absentees 2. Different views with larger group 3. Purpose of group	S	S	S	S  Dr.	G
Agreement with partner		100%*	100%	100%	50%	100%	100%

\*Since Observer A's 2 topics are contained in Observer B's 3, A's record is scored as agreeing 67 per cent with B's, and B's as agreeing 100 per cent with A's.

TABLE 33. Agreement in Sample Records, by Item Analysis

	<i>Complete agreement</i>	<i>Partial agreement</i>	<i>Dis- agreement</i>	<i>Indepen- dently reported by A</i>	<i>Indepen- dently reported by B</i>
	(a)-(a) (g)-(d) (h)-(e) (i)-(g)	(l)-(i) (m)-(l) <sup>1</sup>	(j)-(h)	(b) (c) (d) (e) (f) (k)	(b) (c) (f) (j) (k) (m)
Number	8	4	2	6	6
Per cent (N=26)	31	15	8	23	23

broad aspects of intra-group relationships. Within a given area it enables us to locate various problems for more detailed study of cause and effect. Having made hypotheses that particular problems are relevant to therapy, by means of topic analysis we can rapidly find examples relevant to them.

With respect to the content of group discussions we may want to know, for example, what determines the fact that certain patients or groups dwell on or avoid topics that usually come up in the course

of psychotherapy--such as homosexuality or hostility toward the doctor. Through topic analysis we can easily locate the degree of regularity with which these subjects are referred to; we can then search the full records more closely to discover the relevance for therapy of their presence or absence.

From the first it seemed likely that therapeutic progress was indicated by expansion and increased flexibility of patients' relationships with other group members. Such changes show up readily in the relationship columns of the topic analysis, where we may discover at a glance how a patient who at first never initiates topics begins to initiate them, how one who at first never refers to himself begins to refer to himself as well as to others, and how another who at first tends to speak only to the doctor (as indicated by the fact that no other group members are found participating in topics which he initiated) later brings up topics in which other group members participate. These changes having been located, their determinants and effects can then be studied.

Besides being helpful in the accumulation of data around hypotheses derived by other means, topic analysis may also give rise to certain hypotheses by calling attention to relationships which might otherwise have escaped notice. For example, it was noted that the group which had the greatest number of short, fragmented topics was the one in which the doctor appeared most often in the column headed *Rest*, suggesting a relationship between the doctor's approach and the patients' failure to organize into a group.



## APPENDIX C

### *The Psychiatrist's Evaluation of Individual Patients*

---

METHODS of evaluation which permit comparison of one patient with another and of the same patient with himself at different times are needed in all types of experimental psychotherapy in order (1) to determine the suitability of patients for treatment and (2) to judge the effectiveness of treatment. In group psychotherapy such methods are prerequisite not only for a study of the patient's personality attributes and symptoms in relation to the processes of therapy but also for a study of the principles of group composition (see Chapter IV).

Since the formidable problems involved in developing methods of evaluation are so well known<sup>1-3</sup> they need not be considered here. As explained in Chapter I and elsewhere, our methods were based on the cooperation of psychiatrists, psychologists, and social workers.\* The means by which this cooperation was achieved at the Washington Mental Hygiene Clinic are described below and in Appendices D and E.

Of the three types of workers engaged in the research, the psychiatrist was, of course, in the best position to obtain a complete picture of the patient as an individual and as a member of the group. Because of the intensely personal nature of the therapeutic relationship, he received information which the patient might not be willing to give to anyone else. Moreover, since his appraisal of the patient's condition at any moment partly determined his technique, evaluation of the patient's progress in therapy was an integral part of his task.

By virtue of his special training and experience, the psychiatrist was also equipped to obtain the deepest insights into the patient's problems, but it was inevitable that personal reactions toward the patient should introduce some bias into the situation and that each psychiatrist should report his observations from a different point of

\*Further systematization, simplification, and integration of these methods are still in progress.

view. We tried to reduce these subjective factors to a minimum by basing our evaluations and predictions concerning a patient on a consensus of all who studied his case.

We did not find it practical to formalize to any great degree either the evaluations which psychiatrists made of their patients or the appraisals which were mutually arrived at by the psychiatrist and observers in seminar discussions. Records were kept of these discussions, and each psychiatrist kept clinical notes in his own way.<sup>o</sup> The adequacy of the clinical notes varied widely, depending on the time the individual doctor was able to devote to them and his acumen in selecting and describing events.<sup>†</sup> They ranged from little more than initial and final diagnoses (in a few cases) to very full reports, but at least some of the data described below were available for all patients. We asked each doctor to rate his patients in terms of a simple check list of symptoms, in order to facilitate comparison of each patient before and after treatment. The symptoms in this list were divided into the following categories: *somatic subjective*, arranged by organ system (e.g., headache, cardiac, gastrointestinal, locomotor), *somatic objective* (e.g., startle, fainting, paralysis, stutter), and *psychic* (e.g., anxiety, ruminations, daydreams, depression, feelings of guilt). Severity was indicated as *slight*, *moderate*, or *marked*, and instructions for rating each symptom were provided.

We also asked each doctor to include in his original evaluation a statement of the way he expected the patient to behave in the group and a statement of the changes he expected to see effected by therapy—both predictions to be supported by analyses of the patient's psychodynamics and interpersonal relationships. It was hoped that the formulation of such statements would help the doctor to sharpen his concepts of the goals of therapy for individual patients as well as his concepts of the group dynamics, and that they would thus be valuable from the standpoint both of training and of research.<sup>\*\*</sup> Each doctor was particularly requested to include in his notes any material brought out in individual sessions which seemed pertinent to reactions or behavior in the group, and before each group meeting the observer routinely

<sup>o</sup>This applies only to the doctors at the clinic. The doctors at the hospital did not make detailed notes on individual patients, since the hospital patients did not receive individual therapy in addition to group therapy.

<sup>†</sup>Since all the members of the clinical staff were conducting groups on a volunteer basis in addition to carrying full-time schedules of regular duties, we could not impose more research duties on them than they were willing to assume.

<sup>\*\*</sup>In treatment every doctor must use evaluations and predictions however implicit or tentative; the danger (as one of our doctors discovered) is that his estimates of the patient's progress may be influenced by these predictions.

checked with the doctor on the emergence of clues of this kind. When a patient left therapy or when observation of a group was terminated, the doctor was asked to specify the changes he had noted in the patient, to explain how they seemed to be related to therapy, and to comment on the extent to which his expectations had been fulfilled. The doctors were also requested to describe as far as possible their patients' conflicts and how they were affected by treatment.

Although these impressions were too scanty and too subjective to be used in rating the patients, we took them into consideration in arriving at our over-all conclusions. It seemed to us that there was at least a reasonable possibility of determining at the end of the observation period whether the patient's conflicts had been aggravated by treatment, remained essentially unchanged, or had been slightly or markedly alleviated.

Three types of slight amelioration appeared to be distinguishable:

1. Insight without change of attitudes or behavior. For example, a patient might discover that his difficulties with his employer were related to his attitudes toward a parent. Even though no apparent change followed this realization, we felt that it should be considered a slight improvement, since it afforded hitherto unavailable opportunities for constructive change in the future.
2. Alleviation of symptoms by repression or avoidance of the whole area of conflict, or part of it, without insight. For example, a patient who suffered from intense guilt over masturbation and premarital sex play decreased his discomfort by refraining from masturbation and getting married, without, however, showing any increased insight into his underlying problems.
3. Amelioration by partial working through of conflicts. For example, a patient who became aware during treatment of deep emotional dependence on his mother finally overcame this to the extent of taking the management of his savings out of her hands and of being able to assert himself in her presence, but his relationship with her still blocked any mature relationship with women contemporaries.

It was considered that patients could achieve marked amelioration only by working through their conflicts, and so this category was not further subdivided. For example, in the course of treatment a certain patient managed to discover, analyze, and finally lose his fear of and dependence on his domineering, overemotional father. This resulted in an increase in emotional maturity that was clearly apparent not only in his relationship with this parent, but at home generally, at work, and in his own increased self-respect.

In the final staffing of each patient at the end of the period of

observation, the information supplied by the doctor on the patient's conflicts was considered along with those test and interview results which showed changes in his characteristic responses to stimuli and in his interpersonal relationships.

To sum up—the following special information on each of his patients was requested of each doctor:

At the start of therapy:

1. Diagnosis of the patient's clinical condition, including ratings on the list of symptoms.
2. Statement of the therapeutic goal and the expected effect of group therapy on the patient.
3. Prediction on the patient's behavior in the group.

During therapy:

1. Notes on individual sessions with particular reference to their relation to group meetings.
2. Discussion of each group meeting with the observer.

At the end of therapy:

1. Summary of the changes noted during therapy and of how they seemed related to therapy.
2. Re-ratings on the list of symptoms.
3. Evaluation of changes in the patient's conflicts.

## APPENDIX D

### *The Interpersonal-Relations Interview by the Social Worker\**

---

IN order to evaluate the patient's social adjustment and the changes occurring in it during the course of therapy it was necessary to develop a special type of interview, since certain needs of our research were not met by any of the interviews in the clinic's treatment program† or by any of the standard social service interviews with which we were familiar.\*\* This special type, which we called the interpersonal-relations interview, was designed to obtain:

1. A comparison of the patient before and after therapy in terms of his described or observable behavior and feelings in relationships with others.
2. The patient's own report of his experiences and reactions in the group.
3. Predictions of how patients would behave in groups.

The first two of these aims applied to our work with neurotic patients at the Washington Mental Hygiene Clinic and with schizophrenic patients at the Perry Point Hospital. The third aim was confined to our interviews at the clinic. The work at the hospital could not be completed because of technical difficulties but is reported for the value it may have for others interested in research with schizophrenics on the basis of social-work-interview data.

The objectivity and uniformity required by science are usually obtained, in sociological and psychological research, by the use of standardized tests and questionnaires. In the earliest phase of our study we roughly approximated this approach by obtaining from the patient a minute schedule of his social life (both quantitatively and

\*By Henry S. Maas and Edith Varon.

†The intake social worker concentrated on the patient's social history and eligibility and willingness to accept psychotherapy, the psychologist on the patient's mental and emotional make-up, and the psychiatrist on resolving the patient's emotional conflicts.

\*\*These tend to focus with the client on his problem.<sup>1</sup>



qualitatively), his various activities, how and with whom he spent his time, and the intensity and duration of his feelings. This was the equivalent of a schedule of questions, but it failed to give the meaning of the patient's behavior and to yield data by which his responses could be evaluated. Moreover, it tended to exclude some of the social worker's most valuable contributions from the interview.

In order to understand the patient's social adjustment we needed a great many details. These would include such matters as his ability to express any feelings; the kinds of feelings he expressed; to whom he expressed them, under what circumstances, and by what means. We needed to know how he related to people who were important to him and to those with whom he had only casual contact.\* We needed to know how he perceived people as well as his attitude toward them (e.g., he might describe his wife as a violent, domineering person and yet say that he admired her). Was he a person who could express hostility only to those to whom he felt superior, by making contemptuous remarks? Were co-workers seen largely as rivals or inferiors; were they feared or exploited? Was a particular example of passive behavior an expression of fear, resistance, rebellion, or a need to be pitied and taken care of?

We therefore decided to experiment with a type of interview which would permit the social worker to modify his questions to suit the personality of the patient and also to clarify obscure responses by direct reference to the patient. Since the picture obtained by the social worker naturally represented the way the patient saw himself or the way he wanted the interviewer to see him, it might be lacking in objectivity or it might be distorted because of varying degrees of repression (remaining silent, presenting only one side of a relationship, and so forth). The more flexible method of interviewing thus had the additional advantage of enabling the social worker to take the patient's reaction to the interview into account when he evaluated the patient's distortions. For example, a patient who was hostile to the interview might describe everything as "fine," but in the light of his relationship to the social worker this "fine" would actually represent the patient's unwillingness to talk about his intimate feelings. Hence the success of the interview was as contingent upon the social worker's awareness

\*There is at hand no fully adequate definition of ways of relating. Slavson's classifications of relationships<sup>2</sup> were neither exhaustive nor discrete enough to give us what we needed for a full understanding of our patients. Some of Horney's classifications of the neurotic's ways of relating—moving toward people (compliance), moving away from them (detachment), and moving against them (aggression)<sup>3</sup>—proved useful (see the form on p. 561). However, we were unable to find any classification of relationships that was fully adequate for our purposes.

of relationships between himself and the patient as upon appropriate systematization of the interview procedure.

Following adoption of the more flexible type of interview, we continued to strive for objectivity and uniformity. Each interview was recorded in process form, the interviewer's subjective impressions being excluded from the record, so that other members of the staff might make independent evaluations and check them against that of the interviewer.\* The material recorded on the forms was then conceptualized, condensed, and organized to serve the purposes stated above.

A supplementary method of correcting distortions obtained from the patients was to interview their relatives. In a few instances the information thus obtained did change the picture, as in the case of a patient who presented a very bland personality to the social worker but whose wife told of his uncontrollable rages. Many of our clinic patients had no relatives near by, and only a few of the relatives seen gave information which justified the expenditure of the interviewer's time.† The relatives of the hospitalized schizophrenics were scattered over three states. They had been separated from the patients for years and therefore could not describe the patients' functioning before the onset of their illness. They were often so emotionally disturbed themselves that they could not easily be brought to talk about the patients. In consequence of all this we abandoned the interviewing of relatives.

#### PATIENTS' REACTIONS TO THE GROUP

The first patients to be interviewed had been receiving group therapy for some time.\*\* We therefore used the opportunity to get their reactions to the group. Inevitably, we began to look for dynamic connections between the patient's reaction to the group, and his personality as shown in the interview. Also, as our research progressed, we began to look for ways of predicting, on the basis of the interview, how a patient who was new to group therapy would behave in it.

We assumed that behavior shown in early group meetings was comparable to extra-group behavior. We also assumed that certain aspects of relationships with employers, co-workers, wives, and others outside the group would reappear in similar patterns in the group. We therefore concluded that established behavior patterns, when considered

\*A small sample was studied in this way by another social worker, whose interpretations turned out to be identical with those of the interviewers.

†From our brief experience it seems possible that this supplementary interviewing would be useful with a patient who presents the picture of hysterical character.

\*\*We later found that a patient's report of his reactions to early group meetings was best obtained after he had attended about ten sessions.

in relation to the total group situation, would provide bases on which to predict the behavior of a given patient in a given group. Hence it was believed that the interpersonal-relations interview aided the doctor in planning the composition of groups, in anticipating the development of certain group relationships, and in planning his tactics for early meetings.

In analyzing the patient's initial experiences in the group the social worker focused on the patient's perceptions of and conscious feelings about his relationships in the group. In the final interpersonal-relations interview, when the patient left treatment or at the end of the period of observation, the social worker aided him in taking stock of the effects of group therapy. At this time patients frequently indicated changes in psychodynamics by changed attitudes toward the interviewer as well as by what they reported.

#### THE RELATIONSHIP BETWEEN THE INTERVIEWER AND THE PATIENT

The social worker tried to be as impersonal as possible, so as to avoid influencing the patient's emotional reactions, and to keep the depth of the relationship at a minimum in the hope that differences appearing in re-interviews might be attributable to change in the patient rather than to change in the relationship with the interviewer. He also aimed at getting sufficient details in the patient's own words about his feelings and behavior in order to minimize the need for subjective evaluations.

At the outset the social worker explained to the patient that the interview was not intended to be immediately therapeutic. He avoided becoming involved in the patient's problems, but reassured him when necessary by appropriate referrals. Thus, a patient who brought out his fear that his problem might be due to a head injury was assured that the doctor would look into this possibility. In other instances, referrals for members of the patient's family were made to the clinic social service.

The social worker was careful to see that his relationship with the patient was confined to the interview and that the latter did not become dependent; he aimed to leave the patient with a feeling of closure at the termination of the interview. On the other hand, his interest in and acceptance of the patient made it easier for the patient to talk about himself. The very nature of these limitations to the relationship minimized the patient's anxiety and the risk of his being

disturbed over what he had said or his relationship with the interviewer.

### CONDUCTING THE INTERVIEW

The social worker attempted regularly to investigate those areas of a patient's life which, combined, would give a picture of him as a functioning social being: how he related to various members of his family, to teachers and employers, to peers and co-workers; what he did for recreation; how he got along by himself. Emphasis was laid on getting his reactions to specific day-to-day experiences. In the interpersonal-relations interview the social worker was concerned primarily with the present, but when necessary he went into relevant experiences in the patient's past life and his feelings about them.

The social worker defined the purpose of the interview to the patient by saying that it was to get an over-all picture of him as a person, how he felt and behaved in different situations. With patients who had been in therapy for some time, as happened at the beginning of our research, it was necessary to add that the material was being used for research purposes. This difference in definition had no noticeable effect on the interview.

Once the purpose of the interview had been defined, the situation might be left rather undirected. If the patient obviously wanted to be questioned, the social worker might ask him to describe himself at work or at home or to mention what he considered to be his outstanding characteristics. Given this freedom, the patient often revealed a great deal about himself through his reaction to it. If he showed anxiety because he was not being directed more definitely, the social worker could observe the way the patient's anxiety was manifested. Some patients asked the interviewer for more specific questioning. Others talked so lengthily that it became necessary to redirect them. What they said might give other leads. One would concentrate on his symptoms, perhaps to get pity; another, feeling he must prove his adequacy, might talk about his successes. From the way in which the patient reacted to the opening of the interview, the social worker frequently got cues as to how the patient could most comfortably be approached. If, for instance, he talked about his symptoms, he could be led to talk about situations in which they occurred and from there to the persons who were involved in these situations.

Although no set questions were uniformly used to elicit information about the patient's relationships, certain lines of investigation proved generally helpful. Questions about his feelings in performing chores



or receiving or giving orders at home or at work might throw light on his attitudes toward responsibility and authority. Questions about service experiences might give valuable leads about reactions to authority and to living with contemporaries of the same sex. If the patient had already attended meetings of a group, the interviewer usually explored the way the patient felt toward other patients, how he perceived the doctor, and how he had reacted in the group, in order to find out whether, for example, the group stimulated or inhibited him. Questions about the disciplinary methods or the favoritism of parents might bring out a whole nexus of family relationships and rivalries. If a patient blocked in discussing present family relationships, inquiries might lead him to talk about earlier family situations which clarified the present patterns. If he did not bring out personal material spontaneously, the interviewer might ask how the patient felt in the situations which he had described. If a patient had little to say, the interviewer might also ask him about situations to which he was likely to respond: whether anyone in the family expressed hostility, when this happened, and how he reacted to it. Similarly, for a rounded picture of the patient, we needed to know the conditions under which he experienced happiness. Throughout the interview it was important to obtain specific descriptions of the patient's feelings and behavior which could be compared with similar descriptions obtained later. For example, one of Dr. N's patients first reported that whenever he felt anger he simply thought about it until it went away. In a later interview he said that he banged on the wall—thus indicating greater spontaneity in the expression of feeling.

In general we found that the patient's aspirations for himself—both in life and in therapy—were important indications of his adjustments. They were related to his attitudes toward his own limitations and might also indicate that he was either fulfilling or frustrating his parents' ambitions for him. They were subtly related to his attitude toward therapy, according to whether his goal was to modify himself, to prove the inadequacy of the doctor, and so on.

#### INTERVIEWS WITH HOSPITALIZED PATIENTS

Interviews with hospitalized schizophrenic patients had the same purposes as those with clinic patients, but the hospital setting and the severity of the patients' illness altered the method and content of the interview and increased its difficulty. Changes in the patient's relationships and social behavior in the hospital (his present situation) and his reactions to the group were evaluated. As with the clinic



patient, use was made of fairly general questions which would not suggest any particular answer. Questions dealt with the patient's way of getting along in the hospital, his ability to relate to other patients and to nurses and attendants. Whom did he know by name? What could he say about them? Relatives became part of the situation if they visited the hospital or if the patient was expected to return to them. Since such an interview sometimes produced very little, it was supplemented by collating notes on the patient's behavior in the hospital.

While favorable changes in neurotic patients might first be manifested by changes in their relationships with others, improvement in a schizophrenic might be indicated merely by increased ability to remain in contact with the interviewer. The increase might be manifested by the ability to discuss a greater variety of topics or by the ability to discuss the same topics more understandably or more deeply. We therefore considered exploring the topics on which the patient would talk without relapsing into psychotic behavior as a way of evaluating the change in ego strength which might have resulted from therapy. The social worker noted how far it was possible to go on talking about any subject before the patient lapsed into psychotic language, changed the subject, or became silent or inattentive. For example, one patient in his first interview referred to the therapy group as a "party" and would not talk about anything that had been discussed there. A year later he talked freely about the content of the meetings. He told how much it had meant to him when the doctor, whom he had regarded as omniscient, admitted having made a mistake. He described the topics discussed in the group as "principles of living" which "give you life." He was willing to communicate extensively on what had previously been a closed subject.

We have not done enough interviews with schizophrenics to test the value of this approach. We know that extraneous factors such as disturbances on the ward temporarily influence a schizophrenic's reaction more than a neurotic's in any interview situation. Therefore, the reliability of any one interview is more questionable. A series of interviews might have solved this problem.

### USES OF THE INTERVIEWS

The interview data were studied differently for the purposes of composing groups, evaluating changes resulting from therapy, and determining patients' reactions to the group.

### *Composing Groups*

To facilitate the composition of groups of neurotic patients through prediction of how individual patients would behave toward one another, we abstracted the recurrent patterns of each patient's interpersonal behavior from his initial interview. This pattern emerged from a study of his relationship with the social worker, the uses he made of the interview situation, and his relationships with persons described in the interview. These were always checked with the data of the psychological tests and psychiatric interviews. For example, a certain patient described how, in competition for maternal approval, he had practically excluded his brother from his awareness. He told of how, in classroom discussions, he had responded to the teacher's questions without concern for the reactions of other students. His reactions to the contributions of classmates had usually been critical. In military service his friends had all had higher ratings, and he had little of a favorable nature to say of his peers. From this information we predicted that he would be active in therapy and eager to please the doctor, while tending to ignore or be critical of other patients. We therefore decided to place him in a group of rather passive patients to get things started, while keeping in mind the advisability of having at least one other competitive patient present, so that the group would not be dominated by one patient.

The characteristics that proved most useful in predicting how individuals would behave in therapy groups included attitudes the patient showed with respect to authority and to peers; his ability to reveal his weakness before his peers; his relative aggressiveness, hostility, and tolerance for tension. The use of these data is more fully discussed in Chapter IV.

### *Evaluating the Effects of Therapy*

The data of the interviews had to be organized into categories before they could be used to evaluate changes resulting from therapy. After considering methods for precisely quantifying interview data<sup>4</sup> and the qualitative classification systems of others,<sup>5,6</sup> we decided to limit ourselves to crude qualitative categories. For convenience in organizing material we drew up a form which gives a bird's-eye view of the interpersonal relationships of individual persons. In series it greatly facilitates comparison of the same patient at different times as well as comparison of one patient with another.

The form brings out the similarities and differences in a patient's behavior with different persons and also the confluence or lack of it

### PATTERNS OF FEELINGS AND BEHAVIOR

## Feelings®

### Interpersonal Behavior

\* H-F=hostility-friendliness; I-B=isolation-belongingness; S-I=superiority-inferiority.

\*To be filled in: passive dependence, aggressive control, rebellion and submission, rebellion and negativism, rivalry, detachment, independence, etc.

The feeling entered on the form was always the one that the patient expressed, although we recognized that this might mask one that was quite different. In the latter instance, the underlying feeling was also entered and supporting evidence for it was stated. When possible, we distinguished between emotions expressed directly to their objects, emotions expressed to the interviewer but not to their objects (e.g., "I get angry at my father, but I can't show it"), and those which were repressed (e.g., a certain patient expressed only friendliness toward his wife, but had an anxiety attack while telling of his fear she would have a fatal accident; from this the interviewer inferred that the patient had repressed his hostility toward his wife). Wide discrepancies between what the patient really felt, what he said he felt, and the way he acted were more apt to appear with respect to hostility and

friendliness than with respect to other feelings. Changes in this category after therapy might mean that previously hidden feelings had emerged or that a real change had taken place.

The terms used to describe interpersonal behavior (e.g., "dependent," and "rivalrous") were those which the social workers found most commonly used in evaluations of relationships. We tried to be consistent in our use of terms, but not rigid. A single term was often insufficient to describe a relationship. Since behavior and feelings cannot well be separated, it was often necessary to describe the relationship by combining the two, as in "resentfully dependent." In addition, we classified the general direction of the patient's behavior as "approaching," "avoiding," or "attacking" various persons. It is obvious that the interview yielded data on many aspects of the patient's life for which there was no set place in the form because, strictly speaking, they did not represent feelings or behavior directed toward other persons. These data were noted on the bottom of the sheet. They included spontaneity, freedom of expression, ability to relax, to behave independently, to deal with conflicts, tolerance of self and others, security and confidence.

An example of how a patient was described in terms of the interpersonal-relationships-interview form is given below:

*Pattern of feelings.* It is evident that the patient was covertly hostile toward his siblings, the doctor who treated him in the service, and his current classmates and roommate at college. He felt isolated, "different from others," but rationalized this as a desire "to be free." He felt inferior to his brother, who had remained on the farm at home while he himself had to go into the service, but he professed feelings of superiority in maintaining that he wanted to run for office at college, "to clean up the dirty work in campus politics." In addition, feelings of distrust of his peers emerged side by side with feelings of rejection by them: "They belong to cliques. I'm just an outsider." He expressed moral disapproval of his roommate's smoking and going out nights.

*Pattern of behavior.* Although the patient had officially joined one or two organized religious groups on campus, his movement was primarily away from others in that he ate alone and did things by himself. He related initially with passive dependence to acknowledged superiors—to teachers, whom he liked to have call him by his first name, and to one older girl student whom he counted on to assign him odd jobs when he occasionally dropped into a religious-club office. With other peers, and with siblings when he occasionally visited home, he acted in a superficially submissive way, but his feelings were subtly rebellious and negative.



At his initial interview the patient seemed somewhat guarded and distrustful. At his second interview several months later he was much more spontaneous and very friendly with the social worker. He expressed hostile feelings toward a sister who periodically left her child with the patient's mother; he said that while he had made no direct comment to his sister about his feelings, he had on a recent visit home told his brother off for the first time. On campus he had feelings of belonging: "More people feel as I do. I am in with the small minority." Feelings of distrust seemed to have been dissipated when he said, "I was imagining things were going against me (on campus)." His feelings of disapproval about his roommate and others were replaced by a new feeling of detachment: "He can go his way. I'll go mine. I can't change him." Instead of moving away from all others, he now said that he would "rather be with someone" and that he "liked to share." He referred to going to meetings of the religious club and to concerts with a girl on campus. He seemed in this relationship to be somewhat more aggressive. The negativism and rebellion were no longer evident. He seemed more realistically acceptant of his non-controlling role among college peers. He said that he was "thinking of other things now." The examples of data presented here were multiplied in the interview records of this patient. We concluded that he showed: (a) a decrease in feelings of isolation and not belonging at school, but not in family; (b) a decrease in feelings of distrust and rejection at school, but not in family; (c) somewhat of an increase in congruence between feelings and behavior both at school and in family; and (d) no significant changes in friendliness-hostility or superiority-inferiority feelings. Group therapy records revealed some of the development of these changes in the patient, and psychiatric and psychological evaluations either supported or failed to invalidate findings from interpersonal-relations interviews.

### *Determining Reactions to the Group*

The interpersonal-relations interview also gave us the patient's reactions to experiences and relationships in the group, which could be correlated with our records of group meetings and with our evaluations of the patient. The patient's statements of what he felt had helped or hindered his therapeutic progress might corroborate or modify the inferences we had made about his participation in the group and its effect on him. These data also suggested to the doctors what might be more effective or best avoided with certain patients. For example, one patient said that it had been particularly helpful to learn things



"from a bunch of fellows," supporting the impression that the group supplied the adolescent gang experience that he had missed. Another told the interviewer that he had not been helped by the group because he had to maintain "prestige" with the other members and that he had been unable to reveal his fear that he might be homosexual. These remarks helped explain his exhibitionistic emphasis on sexual exploits, which had impeded the functioning of the group, and indicated the necessity of either making it possible for this type of patient to face his problem in the group or removing him from it.

Interpersonal-relations interviews were of particular value with patients who were comparatively silent in the group and had no concurrent individual therapy. One of these demonstrated greater freedom in facing his own hostile feelings at the close of treatment; another reported that his greatest experience had been to skip a group meeting and not be reproached when he appeared next time.

Considering together the group experiences that a patient reported and his dynamics, we could investigate whether other patients with similar dynamics had similar experiences. If so, prediction of the group behavior of similar new patients might be possible. One patient reported that at the last meeting he attended he felt his word should have been "more final." Reviewing the record of that meeting, we found that the doctor's interpretation of the patient's attitude toward sex was rather painful. The pattern he revealed in his interview showed that he needed to maintain an appearance of adequacy with his peers; the doctor, by making an interpretation which went counter to what the patient was saying, punctured this appearance of adequacy and led the latter to drop out of the group. The accumulation of a number of examples of this kind led us to predict that such patients would tend to leave the group unless the doctor went slowly with them.

The foregoing paragraphs illustrate how the interpersonal-relations interview fulfilled the purposes stated on page 553. In each instance, the social worker's data were coordinated with those of the psychologist and psychiatrist. Differences of opinion seldom occurred about a patient, and in all but one or two instances they were easily resolved by conference. The usefulness of the interview for these purposes, therefore, seems to be well established.

## APPENDIX E

### *Use of the Rorschach Method by the Psychologist\**

---

IN our research project psychological testing was designed to complement the psychiatrists' and social workers' evaluations by contributing to an understanding of the dynamics of therapeutic problems, to an appraisal of the effects of therapy, and to the identification of patients who presented comparable or contrasting characteristics. The tests supplied a constant frame of reference for assessing the patients before, during, and after any therapy and for comparing them with one another. The Rorschach test, upon which we relied most heavily,† yielded data on the patients' ways of perceiving and responding to their environment and indicated those aspects of it which they excluded from awareness as well as those to which they characteristically responded. The Rorschach blots provided standard stimuli. When a patient was re-tested, changes in his responses helped to indicate whether therapeutic progress had been made. Behavior could be predicted on the basis of the test and checked against actual behavior in the group.

#### ANALYZING THE TEST

We examined the test data for what they told about the dynamics of patients' behavior. At first we had lists of random characteristics. We then found that certain ways of functioning were common to all types of patients but differed in degree and quality. By studying these common functions we could compare a patient with himself at different times and different patients with one another. Since we were concerned with the functioning of the patient in his social setting,

\*By Robert MacGregor, Joseph Margolin, and Helen Nash.

†The Wechsler-Bellevue and Thematic Apperception Tests were also used with many patients. The following discussion applies only to the Rorschach. The use of the TAT to cast light on problems of group therapy is being studied.

we tried to find out how he reacted emotionally to his environment, whether he controlled or modified his emotional responses and, if so, how. To express this concept we used the term *accessibility to emotional stimulation*. To complete the picture we used the inclusive term *special personality functions* to describe the *resources* and *defenses* by which the patient interpreted his environment, the term *manifestations of stress* to describe the ways in which the failure of his protective operations was shown, and the term *characteristic attitudes* to describe his interpersonal relationships.

The reader will observe that in themselves such functions do not indicate illness; they are regarded as pathological only when they deviate significantly from the optimum by Rorschach standards. In rating a patient on any function, we were more interested in the relationships between test factors—the *Gestalten*—than in absolute quantities of the many kinds of responses on the Rorschach. For example, we found a decrease in the total number of responses (R) and in the number of whole responses (W) to be as frequently correlated with desirable therapeutic change as was an increase, whereas Muench<sup>1</sup> considered only an increase as evidence of improvement. Moreover, we found the nature of these responses to be a more significant criterion for evaluating improvement than was their number.

All the functions except those pertaining to characteristic attitudes were rated on a seven-point scale (−3 to +3), in which 0 was considered to represent optimum functioning. The extremes represent pathological over- and underfunctioning. These ratings were based on norms for the scoring of the Rorschach test and on the relationship of particular symbols or ratios of symbols to the total protocol. For example, widely differing sums C might represent optimal accessibility in a mental defective on the one hand and an intelligent art student on the other. The diagnosis was made in terms of the extent to which the patient departed from the optimum.

### ACCESSIBILITY TO EMOTIONAL STIMULATION

Accessibility, the first of our four major categories, refers to the manner and extent of the stimulation by standard affective stimuli (Rorschach blots) and the nature of the outwardly directed response that patients make or avoid making to it. The rationale of this section was based on Rorschach's rationale for the color responses, as these proved to be "representative of clinical affectivity."<sup>2</sup>

We studied three aspects of behavior which seemed to be correlated with the patients' response to group therapy:

1. *Extent of accessibility*: the degree to which the patient was stimulated by the affective material.
2. *Affective participation*: the strength and directness of the patient's response to the stimulation.
3. *Control of affective participation*: the control or lack of it which governed the affective responses that the patient actually made.

### *Extent of Accessibility*

By using the usual Rorschach criteria of what is considered an optimal response to affective stimulation (extratensive emotional rapport), we studied each patient's record to determine whether he was either over- or underfunctioning in *accessibility* and the extent to which he did either. We called *overaccessible* those patients who reacted to emotional situations with blocking, repression, or verbal or behavioral upset (i.e., reacting to the color cards with rejection, change in sequence, or loss in intellectual control, other manifestations of color shock, or "flight into color"). We called *underaccessible* those patients who were emotionally unresponsive and who appeared to have little or no warmth of feeling and no evident defense against it (i.e., patients who from all appearances had not been stimulated by color, had not responded to it, and in no way showed that they had "experienced" it). For example, Ingram, an underaccessible patient in Dr. N's Group II, stated several times that he was chiefly concerned because he was so "different" from others—that he did not "feel" as others did. He felt no pity for prisoners when he saw them tortured; he felt no fear when taken for a ninety-mile-per-hour ride by a drunken driver, although everyone else in the car was terrified; he felt no fear when he went behind the enemy lines as a scout. In short, from what one could observe, his emotionality seemed to be limited to concern over his recognition that he did not feel love, hate, and fear as others did. On the Rorschach his responses were characterized by a complete disregard for color. There was no evidence of color shock, and he did not incorporate color in any of his responses.

### *Affective Participation*

To understand further the patient's accessibility, we noted whether he responded directly or indirectly to emotional stimulation and to what degree. (Patients like the one just described, who showed no emotional responses specific to color, of course received no rating on this variable.) Extremely labile patients who were not only highly and frequently stimulated but also responded directly to the stimulus,



were rated as high in *extent of accessibility* and high in *participation* (e.g., Castell of Dr. N's Group II, who seemed to "fly into color"). Patients who were disturbed by affective material but blocked or repressed direct indication of their disturbance were rated as low in *participation*. For example, Veal of Dr. N's Group II, evidenced severe color shock that lasted throughout the test but did not give any responses that incorporated the use of color. He was therefore diagnosed as high in *extent of accessibility* but low in *participation*. In the therapy group he showed corresponding repression. Although he observably became more reticent and blanched, shuddered, or betrayed some other evidence of "nervousness" when upsetting episodes occurred, if the doctor or other patients asked whether he was upset he characteristically maintained that he was not in the least disturbed. Similarly, when questioned about expressions of anger or hostility in his early home life, he could only remember that his parents were "always smiling and happy," despite the fact that he betrayed by inadvertent slips of the tongue that there had been both anger and hostility on numerous occasions.

### *Control of Affective Participation*

Here we used *control* in very limited sense, referring only to the manner and extent of the control governing the affective responses which the patient actually made. Thus, if a patient gave no direct evidence of emotional response to color, he was not scored for this function here, and the other "controls" he used were considered as *defenses* (see *Special Personality Functions*). On the other hand, if a patient's emotional reactions were determined largely by objective formality or intellectual appropriateness, this suggested that he was turning in the direction of *overcontrol* in regard to his emotional rapport with others (seen on the Rorschach in persistent FC, F/C responses). But if a patient persistently reacted with lack of control (seen on the Rorschach in CF- or pure C responses) we tried to evaluate the extent of this *undercontrol*. This might perhaps appear behaviorally in wild rages or temper outbursts. Diagnoses in this area were evaluated in terms of the manner in which lack of *control* was expressed. Although two patients might show lack of control, one patient's responses might be made up entirely of explosions, atomic bombs, and fires, and the inference might be that this patient was given to explosive emotional reactions. The second patient's responses might be limited to maps, painters' palettes, and so on, and might



indicate merely that he became vague and evasive in the face of emotionally threatening situations.

A good example of the way in which a patient's functioning with respect to accessibility on the Rorschach parallels his functioning in the group is given by Castell, a patient in Dr. N's Group II. This patient also illustrates the fact that a person can have excellent intellectual control in some areas and not in others. Castell, who was a sculptor, showed adequate intellectual functioning on the achromatic cards of the Rorschach (good plus quality to F responses) but became severely distorted on the color cards (the F quality of his responses to these cards was almost entirely minus).<sup>\*</sup> Similarly, in an intellectual discussion of art, he proved himself not only highly intelligent but quite objective; it was only when the discussion carried an emotional impact for him that his impressions of himself and others became severely distorted. Since Castell gave 10 C and CF responses in a record of 17 R on the Rorschach (the primary content being devastating explosions and mutilated animals or bodies) he was rated as extremely high in *extent of accessibility*, extremely high in *participation*, and extremely low in *control*, with emphasis on angry and explosive behavior. These ratings were confirmed by his social and group behavior. In the therapy group, although he remained silent most of the time, he responded to almost any expression of hostility by glowering, crying, or berating the patient who caused his disturbance. His social behavior was consistent with his group behavior in that his frequent outbursts of anger caused him to restrict his activities. He said many times that he did not want to make a fool of himself by becoming angry and crying. Here again he chose to be isolated rather than continually upset by what his friends might say or do, and because of fear of what he might do to them if he lost his temper.

To sum up—evaluation of accessibility to emotional stimuli may be said to cast light on the patient's ability to experience and express feelings and on the nature and extent of the emotional responses he is likely to make in therapy. Thus, our interpretations of accessibility could be used to anticipate therapeutic problems. If the doctor sought information about, say, a patient's hostility, the nature of the patient's accessibility might help him understand various questions. To what extent is the patient prone to become hostile? Does he give an angry

<sup>\*</sup>Although our discussion has been limited primarily to a study of the color responses, we wish to emphasize again that their meaning was studied in terms of the context in which they occurred.

response to a hostile situation, and if not what reaction, if any, does he make overtly? If and when he makes a hostile response, is it likely to be a few well-chosen angry words or a physically combative reaction?

### SPECIAL PERSONALITY FUNCTIONS

The second of our major categories of attributes includes certain *personality functions*, in addition to those discussed above, through which any person's behavior can be studied: *accuracy of perception*, *flexibility of response*, *conventionality*, *fantasy*, *conceptualization*, and *activity*.

These functions can be viewed from two standpoints—how they operate to defend the patient from disturbance and how they enable him to deal constructively with his environment. Responses are defensive insofar as they attempt to alleviate a disturbance without correcting its source and hence tend to be repetitive and stereotyped. They are constructively resourceful insofar as they enable the patient to cope with the source of the disturbance through creative or adaptive behavior.

We tried to differentiate the "well" part of the patients by observing the extent to which their responses indicated optimum functioning in these areas of personality. It is, of course, apparent that patients who come to a clinic for therapy do not demonstrate this optimum in all their functioning. However, patients do reveal resourceful behavior in many areas, albeit the range of their constructive behavior is limited by the nature of their illness. Frequently also, patients may be extremely resourceful in one area to the detriment of others. For example, one patient was optimally precise and clear in his evaluation of the situations to which he responded (optimum functioning in *accuracy*) but only at the expense of severely restricting the variety of situations to which he responded; his rigid thinking and stereotyped behavior indicated underfunctioning in *flexibility* and overfunctioning in *conventionality*.

Deviations from optimum functioning are considered to be pathological and due either to deficiency or impairment or to the patient's effort to defend himself from disturbance. In our neurotic patients we assumed that the latter factor accounted for the deviations. We are aware that our list is not exhaustive and that the categories into which the functions are grouped are rather arbitrary. For example, angry behavior, which we considered under the heading *Accessibility to Emotional Stimulation*, might also have been considered a

*defense* (under the heading *Special Personality Functions*), because it served to intimidate the person who disturbed the patient. Similarly dysphoria, which we considered to be a direct *manifestation of stress*, might also have been considered as a *defense*.

### *Accuracy of Perception*

We studied here the sharpness of the patient's critical appraisal of the reality of a situation. Accurate perception depends not only upon the wealth of the individual's past experiences but also upon the prompt availability to him of associative material; hence it is the judgmental function which, even with a good endowment and rich experience, may become impaired. We studied and rated *accuracy* by determining whether there was any deviation from the optimum either in over- or underfunctioning (as evidenced on the Rorschach by the plus or minus quality of responses determined by form).

We considered patients to be overfunctioning in *accuracy* when their thinking and behavior were limited to the exact nature of things and when adherence to the precise and formal served to stifle all creativity or spontaneity. As the following excerpt from Rorschach<sup>3</sup> illustrates, the maximum and optimum of this function are two quite different quantities: "Pedantic and depressed subjects sacrifice almost all the other factors of the experiment in payment for the privilege of having the best forms. So far as form goes, they outstrip the normally intelligent subjects, but in other factors they are far behind so that they approach the reactions shown by imbeciles. . . ." For example, Doon of Dr. X's Group, who could not tolerate in himself or his associates what he considered a deviation from precision and "absolute correctness in every detail," could permit no casualness or relaxation on the Rorschach and responded with a form level of 98% F+. He explained, "It's a bit silly to take a little thing like these cards so seriously, but that's my way."

We considered behavior which indicated that the patient's appraisal of the world was distorted to be an underfunctioning in *accuracy*. Thus, the only patently psychotic patient in the clinic groups grossly distorted his perceptions of everyday social occurrences and similarly responded to the ink blots with gross distortions of their obvious shapes.

### *Flexibility of Response*

We studied here the way the patient made plans, his applications of established thought processes, and his patterns of examining his envir-

onment and responding to it, as well as the degrees of freedom and spontaneity with which he met unexpected situations. Ratings were made in terms of the extent to which the patient did or did not deviate from the optimum, whether by over- or underfunctioning in *flexibility* (as evidenced on the Rorschach by evaluation of the F%, manner of approach and sequence, variability of response and content).

We considered as overfunctioning in *flexibility* those aspects of the patient's behavior which manifested lack of planning or extreme fluidity in thinking, where the patient showed that he considered everything to be related to everything else, tried innumerable fragmentary formulations of a concept without arriving at a satisfactory one, and was unable to carry an idea through to its logical conclusion. We considered as underfunctioning in *flexibility* those aspects of the patient's behavior which manifested excessive rigidity or constriction.

### *Conventionality*

We studied here the extent to which the patient did or did not think and behave in accord with the mores of his cultural group. In accord with Rorschach theories we gave optimal rating to the patient who showed a tendency to conform to most of society's patterns while having the ability to depart therefrom with due consideration for his own needs or the needs of the situation. Such an ability is essential for balanced and realistic thinking. Like the foregoing functions, *conventionality* was studied in terms of the extent to which the patient did or did not deviate from the optimum, whether by over- or underfunctioning, as evidenced on the Rorschach by study of the popular responses (P%), original responses (O%), and animal responses (A%) in relation to the rest of the test performance.

We considered overfunctioning in *conventionality* to be indicated by uncritical acceptance of social or popular standards or slavish response to the dominant thinking around one. Thus, *overconventionality* represented extreme compliance with simple and common routes of thinking and frequently resulted in lack of individuality and restriction in ideas. We considered underfunctioning of *conventionality* to be indicated by exaggerated departures from conventional thinking and behavior—where the individual lost sight of the standards of his culture, as evidenced in the thinking and behavior of the Bohemian, the eccentric, and, to a greater extent, the schizophrenic.

As for the other functions, the meaning of deviations from *conventionality* and the inferences which may be drawn are dependent on the psychopathological setting in which they occur. Coombs, of Dr.



N's Group I, who was rated as extremely low in conventionality may serve as an example. On the Rorschach he gave only one popular response but numerous fanciful, original, and fantastic ones. Just prior to joining the group he had quit his job, left his wife, and in general given up all activities that involve behaving as a responsible male. In the group he frequently used bizarre expressions and presented such near-psychotic fantasies that other patients had difficulty in responding to them. During the course of therapy it became apparent that his rejection of responsibility was closely related to his hostility to his wife and mother and a repressed desire to be dependent on them. He became aware of the fact that he used his strange verbalizations as a way of feeling superior to other group members because he could confuse them and thus "control" them. This patient's lack of conformity seemed to result from his need to dominate others and a desire to flee from responsibility through dissociating himself from society. It should be emphasized that the meaning of the unconventionality shown by the test became clear only in the light of our knowledge of other features of the patient's dynamics and his life history.

### *Fantasy*

In evaluating this function we studied the extent to which the patient enlivened and enlarged upon what he saw to create a fresh, spontaneous, and sometimes original percept. In normal records on the Rorschach the M (movement) responses are considered to indicate the level of natural endowment—insofar as natural endowment comes to expression in wealth and vividness of ideation—a readiness to anticipate, and versatility and flexibility of perceptual and associative processes in general. Optimal behavior is the use of the capacities inherent in the M responses, or *fantasy*, toward a constructive end. In other words, the patient uses this ability to secure a real gain rather than to satisfy fantasy needs or to invent a flood of possible solutions to a problem, no one of which is carried out. Thus, at the one extreme we found overideational and ruminative patients; at the other, those who were characterized by inertia and monotony of response. Individuals of the latter type gave back concrete descriptions, being unable to enlarge upon the stimulus with any constructive ability.

### *Conceptualization*

An optimal ability in *conceptualization* was considered to be shown when the patient selected essential elements from the situation and derived from them a single meaningful response or when he combined



several percepts into a well-integrated concept. This could also be exaggerated into a compulsion to generalize, to organize excessively complex, highly integrated, or vague general responses from the various possibilities offered by a situation, as seen in overcautious, vague, or evasive responses.

Overfunctioning in *conceptualization* was shown by Goodfriend, a patient in Dr. N's Group III, who gave 90% W responses on his first test. They consisted primarily of maps, charts, and other "easy" responses, most of which would apply as well to one blot as to another. Throughout he used stiff, intellectual language and permitted no questioning of any response. These factors were reflected in his behavior in the group, where he continually spoke in clichés and platitudes, giving a formula for every situation. This behavior was related to his efforts to overcome strong doubts of his adequacy. Among the overgeneralizing patients were those who, not unlike the paranoid or compulsive organizer, made strenuous efforts to develop into a system many unrelated elements of the environment.

At the other extreme were the patients who, unable to select any essential qualities, reported the concrete situation as they saw it in simple, atomistic terms. Underfunctioning in *conceptualization*, they showed little originality and ability to make closures (*Gestalten*). Tile, a patient in Dr. X's Group, was so deeply concerned with being in command of any situation that he described every tiny detail of the blots. This fitted in with the fact that he was seriously incapacitated on his job as a contractor because he could not tear his attention away from minutiae and get perspective on the whole job.

Rorschach indicators of the conceptualizing function included the per cent and nature of whole responses, small detail responses, and the Z score, as well as indications of confabulatory or concretistic thinking.

### **Activity**

One very common phenomenon in psychiatric patients is the speeding up or slowing down of thought process and behavior. The optimum is defined as that energy output which meets the needs of the situation.

The hyperactive patient produces a flood of responses which may or may not be useful or rewarding to him. This tendency may appear as a feature of anxiety states or of manic excitement. The hypoactive patient is slow and lacks energy for either thinking or acting. On the Rorschach ratings of the patient's *activity* may be obtained from the

relationship of R to other test factors, especially when R falls below 15 or exceeds 60.

Each of the following examples of test and group behavior demonstrates one of the meanings which an extreme of behavior can represent. Patient A gave 150 responses on his first test and would have given more had he not been stopped by the examiner; in addition, he elaborated every detail on the card, which led to aimless considerations of the blots. In the group he followed the same pattern, which seemed to arise from his excessive need to please everyone around him. On the other hand, Patient B, who was well educated and highly intelligent, gave very few responses, rarely elaborated on a response, and undertook little organization of the blots. In the group he was hesitant and showed a poverty of associations, reactions which were related to his fear of being overwhelmed should he "speak up."

### MANIFESTATIONS OF STRESS

Under this heading we considered the ways in which the patient experienced aspects of stimuli that were not entirely met by affective, resourceful, or defensive responses. From this standpoint we studied the extent to which the patient showed anxiety or a dysphoric mood which indicated that he felt unable to deal with stimuli to his own satisfaction. Patients whose defensive efforts had been unsuccessful frequently gave evidence of discouragement, depression, anxiety, or morbid preoccupation.

#### *Anxiety Reactions*

This term refers to a pathological degree of tension which is not restricted to definite situations and does not appear to be controlled by defense mechanisms and which may be accompanied by agitation, with or without impulsiveness. While "anxiety" may enter into all the functions considered thus far, at this point we are primarily concerned with those overt manifestations that hamper the patient's ability to perform the tasks set by the test as he wishes to. These anxiety reactions were considered to reflect the tensions which resulted from the patient's inadequacy in dealing satisfactorily with problems in his life situation and which might be his major complaints. Estimates of anxiety were based on the way the patient handled the many decisions required in the test situation (conflict in deciding on the sex of figures, expressed inability to formulate an idea or concept, and dissatisfaction

with responses) as well as on test indicators of somatic manifestations of anxiety. Shaded responses might also give useful clues to the presence of anxiety<sup>4</sup>; following an "easy whole" response a shaded response might indicate uneasiness about "getting away with" the appearance of being able to master the situation.

Dysphoria included the usual indications of depression as well as morbid preoccupations with decay, perversion, or weirdness or attitudes of cynicism, fright, or hopelessness.

The variations in our patients were so numerous that we did not have time for the detailed study necessary for devising a satisfactory method of rating anxiety and dysphoria. We looked rather for clues to the meanings the patient might see in the test situations which aroused these feelings, as on one occasion when Castell, the extremely accessible patient referred to above, spoke jokingly about the poor construction of the Rorschach blots and then responded, "A squashed bloody rat which has just been stepped on." Throughout the test his responses presented a mood of gruesomeness, fear, and horror, which were reproduced in the way he viewed his personal relationships. In group meetings he often erupted into anger and tears, crying that some one or other of the group members had insinuated that he was "crazy." It was noted that on occasion he would have one of these attacks immediately after he had spoken derisively of someone else. Although the meaning of this behavior never became entirely clear, it was analogous to that observed during the test.

#### CHARACTERISTIC ATTITUDES AND BEHAVIOR TOWARD OTHERS

The degree to which the data of the psychological tests yielded information that could be used in predicting ways in which individuals would react to interpersonal situations varied from patient to patient. But in every case, from whatever source in the test situation our clues came, we included in our formulation behavior that seemed to deny or to conflict with the inferences we had made in regard to the patient's covert motivations. Hence it was often necessary to use dialectic terms, such as *passive-aggressive* or *dependent-controlling*, in order to express the idea that the patient's behavior was at odds with his unconscious desires. When we used these terms we aimed to show the way in which his feelings were expressed and the situations which brought them out. We tried to discern whether he was dependent, aggressive, or complaining with respect to people significant to him, whether there were significant differences of attitude

toward members of his own or other age groups, toward his own or the opposite sex (he might, for example, see women as weak, contemptible creatures, and men as strong and without blemish). In short, under this heading we discussed the interrelation of all the functions previously defined and tried to give a picture of the patient functioning as a unit in terms of his assets and his liabilities.

The following data are typical of those from which we inferred an *aggressive-controlling* attitude. Bly, a patient in Dr. N's Group II, literally took over the situation during his test. He demanded the examiner's full attention, insisting that she note and locate each response as he gave it. He gave at least fifteen responses to each blot, but on several occasions after the tenth he remarked, "It's a shame to keep you writing so much," and then proceeded to give several more. The animals and people he saw were large, awesome creatures which he admitted were frightening "just to imagine." At one point (top D of Card VI) the examiner asked him to repeat a response which she had not heard clearly. He interpreted her request to mean that she did not know the word and spelled "caduceus," then took ten minutes to define it, adding, "I'm mighty surprised that you don't know that—but since I've caught you up, I've got you in my power now." Shortly after this episode, the patient said he felt quite comfortable in the test situation; he made no further "apologies" to the examiner and ordered her about at his leisure. In group therapy he aggressively ran over other members by talking faster and louder than they, trying to keep both the doctor's attention and the group's focused on himself. After some months of therapy the patient became aware that he did this, as he put it, to appear important and make himself necessary to others.

#### APPLICATION

After organizing the information derived from the Rorschach to complement psychiatric and social work evaluations we applied the data to the study of research problems.

##### *Locating Patients Who Presented Comparable or Contrasting Characteristics*

Each patient's behavior was compared with respect to one or more of the functions described above or to patterns, or syndromes, derived from them. When a particular kind of behavior became a problem in therapy, the following steps were taken to bring psychological data to bear on it:



1. The test protocols of patients who presented similar problems in therapy were studied to determine what was the correlated test behavior.
2. Other patients having similar test patterns were located by examining the protocols to determine whether these patients manifested similar problems in group therapy.

Once behavior which correlated with test patterns had been isolated and studied, hypotheses could be developed for dealing with it. Hypotheses were also developed from studying the techniques of therapy used successfully with patients who had the same problems.

### *Helping to Define the Therapeutic Problem Presented*

In order to formulate a solution to particular therapeutic problems, the psychiatrist and psychologist studied the test results of patients who presented these problems. For example, Winston of Dr. L's Group made little progress despite apparently keen insight into himself and others. Test results revealed that he protected himself with a front of aggressive intellectual criticism and a facility in revealing material which appeared to be intensely personal but which was actually unimportant to him. His apparent insight had been considered a sign of therapeutic progress. In the light of test data it was seen to be resistance to therapy.

Test data were also used in selecting patients to make up new groups in which particular therapeutic problems could be studied. For example, in several groups numerous patients left early in treatment and therapy seemed stalemated for some who remained. Many of the patients who left appeared to be in good control of themselves but were found to have test patterns which suggested that this control was a defense against treatment. These patients were basically excitable people who defended themselves from becoming upset by glossing over emotionally charged situations with circumstantiality and evasions. Under relatively little stress, however, these patients would withdraw from the scene or become acutely disturbed. Examinations of the running accounts of group meetings indicated that when the doctor made penetrating interpretations or else became relatively inactive these patients either became vaguer or left the group entirely. We then studied patients in other groups to determine which of these "fragile front" patients remained. Techniques by which these patients had been treated were then discussed by the psychiatrists. The hypothesis was made that, despite the fronts which these patients put up to mask their insecurity, their threshold of anxiety



was very low and that the doctor would have to be more cautious in the use of direct interpretations if they were to remain in the group or make progress. To test this hypothesis, a group was composed primarily of "fragile front" members (Dr. N's Group III). In leading this group the doctor was careful not to question patients about their behavior patterns until they had established a secure relationship with him and other members of the group.

### *Describing Changes in Patients or Types of Patients after a Period of Therapy*

Tests were repeated at intervals in order to study the changes that had appeared and to determine whether they were in the direction of therapeutic goals appropriate to the individual. For example, re-tests given a few patients after six months of psychotherapy made it appear that they were sicker than at the start. Study of the data in our frame of reference revealed that this applied to two types of patients. On their first tests the patients of the first type had limited their accessibility to emotionally charged situations by adhering to strictly formal responses, but after a short period of therapy they showed less hesitancy in associating strong feelings with personal material and began to express anger and confusion and to discuss socially taboo subjects. These changes were actually consistent with the immediate therapeutic goals for the patients. On their first tests the patients of the second type had revealed that they were easily excitable and that emotional conflicts seriously impaired their effectiveness. The development of a therapeutic attitude in these patients was associated with the acquisition of sufficient confidence to examine situations without being upset by them. This was manifested in later tests by a greater tendency to be guided by the formal aspects of the blots and a decrease in responsiveness to emotionally charged stimuli. Their limited gain in controlling excitability was consistent with early therapeutic goals for these patients even though it meant a temporarily more constricted outlook. Although the test changes in these two types of patients were in opposite directions, both types of changes were consistent with movement toward therapeutic goals.

## APPENDIX F

### *Evaluation of a Patient's Therapeutic Progress*

---

THE following account of the therapeutic progress of a ruminative, isolated patient of the type mentioned on page 64 has been given to illustrate how an integrated evaluation of a patient and his course in treatment was achieved through combining the data of psychiatrist, psychologist, social worker, and group observer in the framework described in Chapter III. The summary sheet at the end represents the evaluation form used for each patient who was treated in the Washington Mental Hygiene Clinic.

#### *Abstract*

A 24-year-old unmarried patient sought treatment because of seclusiveness, depression, apathy, tearfulness, difficulty in concentration and memory, fatigue, weakness, and visual disturbances. Superficially these symptoms seemed related to guilt feelings in connection with masturbation and sex play with a girl; the clinical diagnosis was depressive reaction with hysterical features, moderately severe.

The patient was assigned to Dr. N's Group II, which met twice a week with no concurrent individual therapy. He had an individual session prior to the first group meeting and one terminal interview. He attended thirteen out of fifteen group meetings over a period of two months, ostensibly leaving because of a conflict with his office hours. He had become essentially free of symptoms and had entered into an active social life. A follow-up visit fourteen months later showed that the improvement had been maintained; it seemed to have been due to avoidance of the masturbation and sex play that made him feel guilty and to the experience of acceptance and discussion on an intimate basis by the group.

#### *Initial Picture*

*Presenting problem.* The patient sought treatment for the symptoms mentioned above, which had been aggravated by fear of unemploy-

ment. He worried constantly about being discharged because of several errors he had made in a recent report. He had not felt really well since a "stroke" he had experienced shortly after his discharge from the Army. This occurred while he was seeing his brother off to Europe and shortly after he had kissed a girl whom he had just met and had touched her breast. Everything went blank; his hands seemed to be cut off; he felt very weak and suffered a brief loss of memory. A similar but milder episode occurred later. His concern over masturbation and sex play began after hearing a sermon on the subject six months before he came to the clinic.

*History.* The patient's father had been hospitalized for many years; previously he had been unstable and abusive. There were two boys and two girls in the family. The patient seemed to resent the fact that his mother was possessive toward him and picked his girls for him and yet expressed approval of his brother's exploits and generally more carefree attitude.

The patient had often changed domiciles when he was a small child; eventually he went to live with a maternal aunt, whom he never mentioned, although he spoke of an older cousin who was always "mad." What he recalled of his early childhood was happy; at this period he played constantly with a group of other boys.

After his family moved from South America to the United States he established no close friendships and never joined a neighborhood gang. He attributed this to his language difficulty ("they made fun of my English and hurt my pride") and to lack of money, which prevented him from going to school games. However, he did participate freely in sports. He served 34 months in the Army, 18 of which were spent overseas. He rarely went off the post, and his transfers from one camp to another apparently had more meaning than relationships in any one company.

Until recently sexual activity had been limited to masturbation—with other boys in childhood and compulsive masturbation later. He stated that he had "no nerve for dates with girls."

*Characteristic patterns of social relations and responses to stimuli.* These were originally determined from the clinical, social work, and psychological interviews before group therapy. Confirmatory material from his behavior in the group is included.

1. The patient was typically compliant but with an undertone of hostility to authority figures. He was overly polite and deferential and waited for guidance in the interview situations. He answered questions circumstantially without emotion, stressing external events. He expressed no feelings toward his parents and discussed no per-

sonal relationships but gave numerous details in regard to moving from one camp to another during the war. On the Rorschach test he stuck closely to the formal aspects of the blots and to the examiner's instructions.

Although he regularly expressed criticism of authority, he invariably retracted it and made excuses for the persons he had accused. In his responses to the Thematic Apperception Test the heroes originally had bad intentions but invariably performed good deeds before the patient concluded his story. In his interpersonal-relations interview he described an older cousin who was "angry but nice." At a group meeting he told about an Army sergeant who was a tyrant and who used filthy language but only because "the officers told him to." At various other times the patient said that his teachers at school "were not very clear but were nice" and that the Army officers were "dopes"—adding, "But probably smarter than I am."

2. The patient tended to deal with disturbing situations by avoiding them. He avoided social as well as intimate relationships. On the Rorschach test he tended to ignore the figures in the blots and to respond to the white spaces and the edges. These findings were confirmed in the course of his treatment, during which he avoided sex stimulation by keeping away from girls. He finally left treatment because it threatened to come closer to his problem.
3. The patient was unwilling to assume responsibility. He preferred not to have demands made on him and in general tended to define situations as unimportant and not requiring anything of him. This was closely related to his compliance and lack of ambition and self-assertion.

On the Rorschach test he rarely made an abstraction of a total blot; when he did, his responses usually indicated poorly organized perceptions but occasionally demonstrated that he could do very well. He characteristically chose the simplest area to interpret and gave the simplest possible response. These findings were out of keeping with his I.Q. of 130 and sporadic good performances.

He structured the settings of his stories to the Thematic Apperception Test by explaining, "There is nothing one can do about it, because the hero is only an ordinary person and must obey the authority." He liked his job, he said, "Because nobody tells me what to do." His avoidance of the obligation of good performance was apparently related to the fact that his performance was well below his potentialities. The impression he gave of unwillingness to assume responsibility and lack of self-assertion was borne out by vague statements about his goals, by his submissiveness in allowing his



mother to choose his career for him, and by his need to have others take the initiative in personal relationships. It seemed that by avoiding initiative and responsibility he escaped overt anxiety but at the cost of misinterpreting stimuli. Unconscious anxiety could be inferred from his difficulties in concentration, his sense of guilt, and his extremely poor performance.

4. The patient's fantasy was immature and childish. On the Rorschach test his spontaneous responses (movement) were those of an adolescent rather than of a mature adult. This immaturity was confirmed by certain responses in group meetings. His advice to a fellow patient (who was puzzled over vocational aims) was to "strike oil or become a movie magnate." He said that he himself might have become "a colonel or a general" in the Army.

### *Modifications after Treatment*

When the patient left treatment his only complaint was a slight difficulty in concentration. His Rorschach performance showed that his concentration and attention had improved. He was "full of pep." He had resumed interest in athletics and enjoyed going to parties. Since giving up his sexual activities, he no longer felt guilty.

Fourteen months later he seemed cheerful, self-confident, and perhaps somewhat less deferential than before. He said that he had continued to feel better, despite occasional sexual activity of the type that had upset him before. He no longer believed that masturbation had caused his illness, since he had masturbated for a long time. He thought that his other sexual activities might have had something to do with it, but he did not seem to feel they could be entirely responsible. He did not consider himself as well as he had been before the onset of his illness but believed that this was due to responsibilities incurred by his recent marriage. He considered himself much better than when he sought treatment. He was sometimes slightly depressed and worried about the future, but he had realistic plans. Concentration on his work remained difficult.

### *Characteristic Patterns of Social Relations and Responses to Stimuli*

*Compliance.* The patient remained compliant toward the doctor throughout treatment but became a little more self-assertive in that he spoke of influencing a friend. He began to express negative feelings toward his mother without retracting them and to tease her. This may have been related to having become less hostile underneath. He spoke of being less sensitive and not so much against life. Fourteen months later he told of openly losing his temper at his associates.



*Avoidance.* Although more avoidant than before of disturbing sexual stimuli, he became less avoidant in social relations with his peers. He became less isolated, now spoke of having a few friends, of participating in bowling and attending sports events, and of liking to go to parties.

*Responsibility.* During treatment he looked for the causes of his symptoms. Although concerned about his marital responsibilities, he showed a slightly greater tendency to see tasks as requiring something of him. On the Rorschach test he showed an increased ability to stay with cards and examine them, although he was still disturbed by color and tried to avoid it.

*Immaturity.* There was some evidence in the Rorschach test of a more mature approach. Many of his responses showed a qualitative improvement and he showed a greater tendency to see people rather than animals in movement.

### *Therapeutic Course*

*Initial interview.* He was deferential and compliant, talking chiefly about his preoccupation with guilt over his sexual activities. He was told that they were physically harmless, but that his symptoms might be related to guilt over them. He raised no objection to being assigned to a therapeutic group.

*Group sessions.* His course in the group may be conveniently divided into two phases. In the first (Meetings 1-4) he moved from the periphery to the center of the group. In the second (Meetings 5-15) he oscillated between withdrawal and increased participation. He showed increasing flexibility and range of relationships and discussed more aspects of his problems. He started with somatic symptoms, went on to sexual problems, and then turned to his feelings of inadequacy and attitudes toward authority. He left therapy, ostensibly because of a conflict of meeting times with his work, as the group discussions became more intimate.

#### *Movement from Periphery to Center of Group (Meetings 1-4)*

Throughout Meeting 1, at which hostility to wives and doctors was discussed, the patient, together with two others, remained silent. At first he stared at his foot, but toward the end he looked at those who mentioned football games and lack of self-confidence. (Later he said that he had been confused during this first meeting.)

In Meeting 2 he participated slightly but without revealing anything of himself. He responded briefly at the start to the doctor's request

to each patient for his name and symptoms. When Thomas, a dominating member of the group, commented on his silence, he replied inaudibly but promptly and showed real, although silent, interest in a discussion of somatic complaints. Subsequently, he joined obliquely in the objection to an earlier observation by the doctor that Thomas' sweating palms might be due to emotional tension. When Mason said that he was sweating even though he was relaxed, the patient added, "The room is also very warm." The group responded with laughter.

In Meeting 3 he was much more animated and participated freely, comfortably, and with some flexibility, but he avoided personal matters and became silent during a discussion of family difficulties. However, he showed several marked changes in behavior. He opened the meeting by spontaneously telling the doctor that he was much better except for a little trouble in remembering things. He showed an interest in three other patients: he asked what caused Bly's sighing and said that he also sighed; made a suggestion in response to Thomas' statement that one doesn't get mad with those close to one, differed with Thomas about the meaning of the latter's job to him, and subsequently asked with apparent interest with whom Thomas played baseball; and finally joined the others in advising Teaney about vocations.

In Meeting 4, under mild pressure from the doctor and Thomas, he revealed a painful sexual problem, which he claimed to have solved. He held the center of the stage for almost an hour. In answer to a question from the doctor he spoke of having a headache because his pastor had said another war was coming. Thomas (the authoritarian patient who seemed to mean the most to him) first agreed with him that war was likely, then agreed with the doctor that the main issue was not the possibility of war but why it upset the patient so much. The doctor reminded him that something the pastor had said applied directly to his problem. At first he couldn't remember, but later interrupted a discussion of hostility toward officers to mention his fear of being punished after death because of his sexual activities. Although saying he had not indulged during the past week and was therefore no longer concerned, under questioning from the others he hesitantly described his sexual conflicts and became the focus of an increasingly animated discussion. All the other members, led by Thomas and Mason, questioned, advised, and commented. He responded directly and without evasion.

*Oscillation between Withdrawal and Increasingly Self-assured  
and Self-revealing Participation (Meetings 5-15)*

*Withdrawal.* At Meetings 5 and 6 he arrived late and was silent

throughout, while the group discussed problems of health, wives, siblings, and officers.

*Participation.* In Meeting 7 he was again late, but for the first time he persistently questioned Thomas about his combat experiences and Flower about his relationship with his girl. He did not reveal his own attitudes.

*Withdrawal.* He was absent from Meeting 8. Although he knew that a substitute doctor would be present, it was not clear whether this was the reason for his absence.

*Participation.* In Meeting 9 he talked about Thomas' leaving soon for Europe. He asked Teaney about his religious discussions with his girl, joined the others in advising Teaney, and for the first time angrily questioned another patient who had attacked Thomas. He said nothing about himself except that he was almost well but wanted to stay in the group.

At Meeting 10 he spoke of a slight recurrence of his depression and talked freely with the others about his personal problems other than the sexual one (which seemed no longer to concern him), including his lack of self-confidence, hostility toward officers, and his belief in body-building. He sought answers from the doctor in a dependent way. At the doctor's repeated invitations to talk about his depression, he said that he had felt low since speaking on the telephone to his brother who had just returned from overseas. He got a laugh when he likened himself to Walter Mitty as never having a chance to make his own decisions, adding that he differed from Mitty, for whom there was no hope. He referred to Army officers as "dopes," and expressed resentment that he had beaten his brains out in the ranks. He had a discussion with Thomas and Hare about his goals, saying that he might have been a colonel or a general if he had enlisted earlier and remarked that his mind dwindled without exercise. After the meeting he asked the doctor what was wrong with him.

In Meeting 11 he continued as in Meeting 10. He defended psychotherapy against the doubts of two other members, cited an experience parallel to Flower's about language difficulties and defended to Hare his belief in the importance of athletics in building up his body, keeping his mind alert, and himself out of trouble. Later he advised Hare and asked him for a cigarette. In connection with body-building he commented that his father had been a champion athlete. (This was his first mention of his family.) After the meeting he asked the doctor how he was progressing.

*Withdrawal.* In Meeting 12, just before his brother's expected return, he participated practically not at all except to deny the doctor's

implied suggestion that his depressions might be related to his brother, since the first occurred when he left, and the present mild depression occurred on his return. He missed Meeting 13 and was silent throughout Meeting 14 except to mention at the very end that his brother was back and that he could not attend subsequent mid-week meetings because of a change in office hours.

*Participation.* In Meeting 15, his last, he returned to the free, self-assured, relatively self-revealing participation of Meeting 11 and went off with another patient at the end. He offered an experience parallel to Bly's by saying that he became angry with himself for getting home late when his mother did not reproach him; volunteered that his fiancée sometimes became angry with him now but would do as he said after they were married. When Thomas advised agreement between husband and wife, he replied that his fiancée was choosing the furniture. He then questioned Thomas about his war experiences. He remained silent during the discussion by others of marital difficulties.

### *Terminal Interview*

The terminal interview was devoted to a review of the patient's progress, his own explanations of it, and his attitudes toward the group. He was told that further treatment was always available and that he should not wait to seek it until he became badly upset.

## FACTORS INVOLVED IN THE THERAPEUTIC RESULTS

### *Terminal and Follow-up Interviews*

In terminal interviews with the doctor and social worker and in a follow-up interview with the doctor the patient discussed the effects of therapy.

*Effect of the doctor.* The patient showed conflicting feelings about the helpfulness of the doctor. He said that he had stopped masturbating because the doctor had told him that his depression was due to guilt. He had felt badly at the time about talking in the group and would not have done so except that the doctor "was beating for" him to talk, but later he felt that he had done the right thing. He criticized one patient for never having told the doctor what his problem was: "If he wants to get cured, he must tell all." About another patient, whom he liked, he asked, "But why didn't he come to earlier meetings, if he really wants his troubles cleared up?" When patients told their



troubles, he said, the doctor should be left to handle them. On the other hand, while a "doctor of psychiatry" was smarter than the average, he lived more or less in his own little world. The doctor might have grown up the same way as other fellows but he had gone far beyond that; he was more like a leader. The doctor, being somebody special who was used to this kind of thing, was not so reassuring to him as the patients, who were average men.

Fourteen months later he mentioned the doctor as a factor in his improvement only as an afterthought, and as if not to hurt the doctor's feelings. When the doctor asked the patient how he might have helped, the latter said, "You were always calm." He did not recollect what the doctor had said about masturbating.

*Effect of the group.* The patient said he felt that he had been helped by the group—that it was good for things to come from a bunch of guys. It had been most helpful when the men really talked about their problems, but not much use when they wandered all over the place. When he had talked freely (Meeting 4) he was helped by reassurance from the men that what he did was not abnormal. The only patient whom he considered individually helpful was "maybe" Mr. Thomas, who had a "strong will" and put "his ideas across clearly." He desired more social experience in the group; he said that he felt the members were not close enough and recommended that they go to the movies and ball games together.

Fourteen months later he was not sure what had made him get better but thought "it must have been partly the treatment," because he had been getting "worse and worse" before coming to the clinic. When asked whether it was chiefly the doctor or the group that had helped, he said that it was the group—"They were pretty good guys, who felt free to talk. I said things there I wouldn't say again even to friends." He asked spontaneously what had become of eight of the group members, identifying each by a significant detail of appearance or history. He stated that he had wanted to continue coming to the group but had stopped because the doctor told him to.

*Other factors.* The patient attributed the solution of his sexual problem to his marriage but said that he had felt worse after it than before because of the increased responsibilities it brought. When questioned, he said that he did not believe his mother had played any role. He cast no further light on the possible role of his brother, saying only that they had not been seeing much of each other. He was emphatic in denying that the church played any part in his improvement. He said that he had not talked with his pastor while under treatment.



### *Evaluation by the Staff*

*Nature of the patient's improvement.* The patient made a rapid, dramatic symptomatic improvement, but its depth was difficult to evaluate. That it was more than the spontaneous lifting of a recurrent depression was suggested by the facts that, according to his own statement, the patient had been getting worse for about a year before seeking treatment and that, in the fourteen months following the termination of treatment, he had continued to feel better and to mix more freely with others. His ability to experience and express anger seemed to be something entirely new.

*Role of extra-therapeutic factors.* The roles of his mother and brother could not be evaluated, but it was suspected that they had been important. The mother stated that she had told the patient to see less of girls and that this had helped him, but fourteen months later the patient had no memory of this—an amnesia which might or might not be significant. The meaning of his brother's return during treatment was unknown. That it was in some way important was suggested by the facts that the onset of his illness occurred when seeing his brother off, that he had a mild depression when his brother returned, and that this coincided with a period of relative withdrawal from the group.

A third extra-therapeutic factor whose influence was unclear was the new work schedule which conflicted with the group's mid-week meeting. It would still have been possible for him to attend the Saturday meetings. The doctor did not urge him because of doubts as to the efficacy of intermittent attendance and because the immediate goal of symptomatic relief had been achieved. The patient indicated later that he had wanted to continue.

The most important event in his life since the conclusion of treatment was his marriage, which had at least superficially alleviated his sexual problem. However, this was counterbalanced by the increased responsibilities it had brought. The patient originally attributed his improvement to avoiding guilt-producing activities; in a follow-up interview he said that he had continued them on one or two occasions but without the previous excessive guilt and depression.

*Role of the doctor in therapy.* The doctor appears to have helped initially as an authoritarian figure. At first the patient probably found it easier to give up his disturbing sexual activities because he believed that in so doing he was complying with the doctor's wishes. Fourteen months later, however, what he chiefly remembered about the doctor was that the latter was "calm," suggesting a contrast to his father and the "angry" cousin of his childhood. It would appear that the doctor

aided chiefly by being mildly directive and acceptant while the patient ventilated his guilt, hostility, and self-doubts in the group. The doctor may have temporarily represented the "good father" that the patient had lacked.

*Role of the group in therapy.* The main weight of therapy seems clearly to have been carried by the group, despite the patient's apparent conflict about it, as shown by his oscillatory pattern of participation and withdrawal. He started as a bewildered onlooker and wound up as a full-fledged participating member. He stressed that it was "good for things to come from a bunch of guys," found it helpful when they talked about their problems, and expressed a wish for more social activities with them. Fourteen months later he spoke of the group as the main factor in his improvement, stressing the opportunity for intimacy. The group seems to have given him the experience of acceptance by a gang which he had missed in adolescence. His success in utilizing this may have been due to his acceptance in early childhood by a group of boys. With the therapeutic group he was advisory, closely questioning, disagreeing, even occasionally hostile. In addition, interactions with group members enabled him to ventilate his hostility and resentment toward persons outside the group. It was probably easier for him to be non-compliant with his peers than with the doctor, but he was encouraged to be more independent by observing the doctor's acceptance of the attacks of other patients. In Meeting 2 he was able to disagree indirectly with the doctor by linking to another patient who had done likewise. By Meeting 12 he flatly disagreed with the doctor's suggestion that his depression might be related to his brother's return.

The interested, acceptant attitude of the others and their willingness to tackle their personal problems may have helped the patient face his own to a slight degree, although his avoidance of them was still much in evidence at the end of treatment. However, in Meeting 4 the group had held him to a discussion of his sexual problems for over an hour (despite his denial that they still existed), and in Meeting 10 the group kept him working on his lack of confidence. That the patient valued this aspect of therapy is indicated by his repeatedly stressing the intimacy of the group.

In brief—the patient's symptomatic relief seems to have been a result of compliance with the doctor in avoiding what he (mistakenly) thought the latter believed to be the cause of his difficulties. The role of the group seems to have been of deeper significance in modifying his characteristic responses. A calm father substitute and a gang

had accepted him. The gang shared experiences with him and supported him. He was thus encouraged to form similar relationships outside the group, and he became somewhat more independent and realistic, without, however, any resolution of his deeper problems.

#### SUMMARY

GROUP SESSIONS: Attended 13, missed 2.

INDIVIDUAL SESSIONS: Attended 2, missed 0.

DURATION OF TREATMENT: 2 months.

FINAL ADJUSTMENT:

*Symptoms.* +2 (markedly improved).

*Social adjustment.* +2 (markedly improved).

*Characteristic responses.* +1 (slightly changed).

#### INITIAL PICTURE

*Symptoms.* Depressed; weak; memory and concentration difficulties; severe guilt over sexual conflicts centering on masturbation. Visual disturbances.

*Relationships.* Compliant but with an undertone of hostility toward authority figures such as mother, teachers, officers. Felt isolated and avoided everyone but a few girls. Felt inferior to others.

*Characteristic responses to stimuli.* Lacked self-assertion, unwilling to assume responsibility. Immature fantasy life.

#### CHANGES

*Symptoms.* Gone except for slight concentration difficulty.

*Relationships.* Less repressed. Fewer feelings of hostility and increased ability to express them. Markedly increased self-confidence, with greatly diminished sense of isolation and increased ability to take the initiative and to assert himself.

*Characteristic responses to stimuli.* Less immaturity. Showed willingness to assume greater responsibility and increased accuracy of thinking.

#### RELATION OF THERAPY TO CHANGES

The attitude of the patient to the doctor suggests that the latter was seen as an acceptant person who was mildly and benevolently directive as he recognized the patient's problems. The group was helpful in that it repeated a satisfying childhood experience of acceptance by a group, which the patient had missed later. He was able to live out his contradictory attitude toward the therapy group and to learn from the attitudes and experiences of its members.



## REFERENCES





## *List of References*

---

### CHAPTER I

1. Burchard, E. M. L., et al. "Criteria for the Evaluation of Group Therapy," *Psychosom. Med.*, 10:257-274, September-October 1948.
2. Klapman, J. W. *Group Psychotherapy: Theory and Practice*. New York, Grune & Stratton, 1946.
3. Foulkes, S. H. *Introduction to Group-Analytic Psychotherapy. Studies in the Social Integration of Individuals and Groups*. London, William Heinemann, 1948.
4. Ackerman, N. W. "Interview Group Psychotherapy with Psychoneurotic Adults," in *The Practice of Group Therapy* (Chap. vii), edited by S. R. Slavson. New York, International Universities Press, 1947.
5. Ackerman, N. W. "Some Theoretical Aspects of Group Psychotherapy," in *Group Psychotherapy: A Symposium* (pp. 117-124), edited by J. L. Moreno. New York, Beacon House, 1945.
6. Slavson, S. R. *Analytic Group Psychotherapy*. New York, Columbia University Press, 1950.
7. Wolf, A. "The Psychoanalysis of Groups," *Am. J. Psychotherapy*, 3:525-558, October 1949; 4:16-50, January 1950.
8. Schilder, P. "The Analysis of Ideologies as a Psychotherapeutic Method, Especially in Group Treatment," *Am. J. Psychiat.*, 93:601-617, November 1936.
9. Schilder, P. "Results and Problems of Group Psychotherapy in Severe Neuroses," *Ment. Hyg.*, 23:87-98, January 1939.
10. Burrow, T. "The Basis of Group-Analysis, or the Analysis of the Reactions of Normal and Neurotic Individuals," *Brit. J. M. Psychol.*, 8:198-206, Part III, 1928.
11. Bion, W. R. "Experiences in Groups," *Human Relations*, 1:314-320, No. 3, 1948; 1:487-496, No. 4, 1948; 2:13-22, No. 1, 1949.
12. Bierer, J. (editor) *Therapeutic Social Clubs*. London, H. K. Lewis [1948].
13. Wender, L. "Group Psychotherapy: A Study of Its Application," *Psychiatric Quart.*, 14:708-718, October 1940.
14. Lazell, E. W. "The Group Treatment of Dementia Praecox," *Psychoanalyt. Rev.*, 8:168-179, April 1921.
15. Mann, J., and Semrad, E. V. "The Use of Group Therapy in Psychoses," *J. Social Case Work*, 29:176-181, May 1948.

16. OSS Assessment Staff. *Assessment of Men: Selection of Personnel for the Office of Strategic Services*. New York, Rinehart, 1948.
17. Ruesch, J., and Bateson, G. "Structure and Process in Social Relations," *Psychiatry*, 12:105-124, May 1949.

## NOTE

A therapeutic approach similar to ours has been reported by: Hinckley, R. G., and Hermann, L. *Group Treatment in Psychotherapy: A Report of Experience*. Minneapolis, University of Minnesota Press, 1951.

## CHAPTER II

1. Alexander, L. "General Principles of Psychotherapy," *Am. J. Psychiat.*, 106:721-731, April 1950.
2. Cohen, M. R., and Nagel, E. *An Introduction to Logic and Scientific Method* (p. 192). New York, Harcourt Brace, 1934.
3. Gill, M. M., and Brenman, M. "Research in Psychotherapy: Round Table 1947," *Am. J. Orthopsychiat.*, 18:100-110, January 1948.
4. Bales, R. F. *Interaction Process Analysis*. Cambridge, Mass., Addison-Wesley Press, 1950.
5. Lippitt, R. "An Experimental Study of the Effect of Democratic and Authoritarian Group Atmospheres," *University of Iowa Studies in Child Welfare*, 16:43-195, No. 3, February 1940.
6. Zander, A. F. "The WP Club: An Objective Case Study of a Group," *Human Relations*, 1:321-332, No. 3, 1948.
7. Snyder, W. U. "A Comparison of One Unsuccessful with Four Successful Non-directively Counseled Cases," *J. Consulting Psychol.*, 11:38-42, January-February 1947.
8. French, J. R. P., Jr. "The Disruption and Cohesion of Groups," *J. Abnorm. & Social Psychol.*, 36:361-377, July 1941.
9. Benedict, R. "Child Rearing in Certain European Countries," *Am. J. Orthopsychiat.*, 19:342-350, April 1949.
10. Dewey, J. *Logic, the Theory of Inquiry* (p. 498). New York, Henry Holt, 1938.
11. Sullivan, H. S. "Conceptions of Modern Psychiatry," *Psychiatry*, 3:1-117, February 1940.
12. Thomas, W. I., and Znaniecki, F. "The Definition of the Situation," in *Readings in Social Psychology* (pp. 76-77), edited by T. M. Newcomb and E. L. Hartley. New York, Henry Holt, 1947.
13. French, T. M. "Research in Psychotherapy," *Am. J. Psychiat.*, 105:229-230, September 1948.

## NOTE

Problems of research in group psychotherapy have been summarized in: Frank, J. D. "Group Psychotherapy in Relation to Research," *Group Psychotherapy*, 3:197-203, August-December 1950. *Idem*. "Some Problems of Re-

search in Group Psychotherapy," *The International Journal of Group Psychotherapy*, 1:78-81, April 1951.

A more detailed discussion of the relationship between the doctor and the observer appears in: Nash, H. T., and Stone, A. R. "Collaboration of Therapist and Observer in Guiding Group Psychotherapy," *Group Psychotherapy*, 4:85-92, Nos. 1 and 2, April-August 1951.

### CHAPTER III

1. Ash, P. "The Reliability of Psychiatric Diagnoses," *J. Abnorm. & Social Psychol.*, 44:272-276, April 1949.
2. Lewin, K. "The Conflict between Aristotelian and Galileian Modes of Thought in Contemporary Psychology," in *A Dynamic Theory of Personality* (pp. 1-42). New York, McGraw-Hill, 1935.

### CHAPTER IV

1. Loeser, L. H. "Group Psychotherapy in Private Practice: Preliminary Evaluation," *Am. J. Psychotherapy*, 3:213-233, April 1949.
2. Wolf, A. "The Psychoanalysis of Groups," *Am. J. Psychotherapy*, 3:525-558, October 1949.
3. Pfeffer, A. Z., Friedland, P., and Wortis, S. B. "Group Psychotherapy with Alcoholics: Preliminary Report," *Quart. J. Stud. on Alcohol*, 10: 198-216, September 1949.
4. Maas, H. S. "Personal and Group Factors in Leaders' Social Perception," *J. Abnorm. & Social Psychol.*, 45:54-63, January 1950.

### CHAPTER V

1. Bion, W. R. "Experiences in Groups," *Human Relations*, 1:487-496, No. 4, 1948.

### CHAPTER VI

1. Varon, E. "Recurrent Phenomena in Group Psychotherapy," *Internat. J. Group Psychotherapy*, vol. 3, no. 1 (1953).
2. Ezriel, H. "A Psycho-Analytic Approach to Group Treatment," *Brit. J. M. Psychol.* 23:59-74, Parts 1 and 2, 1950.

### CHAPTER VII

1. Powdermaker, F. B., and Frank, J. D. "Group Psychotherapy with Neurotics," *Am. J. Psychiat.*, 105:449-455, December 1948.
2. McDanald, E. "The Masking Function of Self-Revelation in Group Therapy," *Internat. J. Group Psychotherapy*, 1:59-63, April 1951.

3. Fearing, J. M., and MacGregor, R. "Analysis of the Group Process in the Therapeutic Session," *Internat. J. Group Psychotherapy*, 1:126-129, June 1951.

## CHAPTER XV

1. Mann, J., Menzer, D., and Standish, C. "Psychotherapy of Psychoses: Some Attitudes in the Therapist Influencing the Course of Treatment," *Psychiatry*, 13:17-23, February 1950.

## CHAPTER XIX

1. Dembo, T., and Hanfmann, E. "The Patient's Psychological Situation upon Admission to a Mental Hospital," *Am. J. Psychol.*, 47:381-408, July 1935.

## APPENDIX B

1. Kelly, E. L., and Fiske, D. W. "The Prediction of Success in the VA Training Program in Clinical Psychology," *Amer. Psychologist*, 5:395-406, August 1950.
2. Fisher, R. A. *Statistical Methods for Research Workers*. (6th ed.) Edinburgh, Oliver and Boyd, 1936.

## APPENDIX C

1. Oberndorf, C. P., Greenacre, P., and Kubie, L. S. "Symposium on the Evaluation of Therapeutic Results," *Internat. J. Psycho-Analysis*, 29:7-33, 1948.
2. Ruesch, J. "Experiments in Psychotherapy: 1. Theoretical Considerations," *J. Psychol.*, 25:137-169, January 1948.
3. Bronner, A. F. (chairman), Kubie, L. S., Hendrick, I., Kris, E., Shakow, D., Brosin, H. W., Bergman, P., and Bibring, E. "The Objective Evaluation of Psychotherapy. Round Table, 1948," *Am. J. Orthopsychiat.*, 19:463-491, July 1949.

## APPENDIX D

1. Levine, R. "Case Worker's Stake in Research," *J. Social Case Work*, 27:151-155, June 1946.
2. Slavson, S. R. "Types of Relationship and Their Application to Psychotherapy," *Am. J. Orthopsychiat.*, 15:267-277, April 1945.
3. Horney, K. *Our Inner Conflicts: A Constructive Theory of Neurosis*. New York, Norton, 1945.



4. White, R. K. "Black Boy: A Value-Analysis," *J. Abnorm. & Social Psychol.*, XLII:440-461, October 1947.
5. Lasswell, H. D. "A Provisional Classification of Symbol Data," *Psychiatry*, 1:197-204, May 1938.
6. Frenkel-Brunswik, E. "Dynamic and Cognitive Categorization of Qualitative Material: II. The Application to Interviews with the Ethnically Prejudiced," *J. Psychol.*, XXV:261-277, April 1948.

## APPENDIX E

1. Muench, G. A. *Evaluation of Non-directive Psychotherapy by Means of the Rorschach and Other Indices*. American Psychological Association, Applied Psychology Monographs, No. 13. Stanford, Calif., Stanford University Press, 1947.
2. Rorschach, H. *Psychodiagnostics* (p. 76). New York, Grune & Stratton, 1942.
3. Rorschach, H. *Psychodiagnostics* (p. 57). New York, Grune & Stratton, 1942.
4. Binder, H. *Die Helldunkeldeutungen im psychodiagnostischen Experiment von Rorschach* (pp. 1, 2, 3, 4). Zurich, Art Institut Orell Füssli, 1932.



## INDEX



# Index

S. A. = situation analysis; t = table.

- Abrahams, J., 2, 335  
Absence of doctor, reactions to, 283, 285, 437  
Absence without leave, 344, 345 t, 346, 352, 353 t, 354, 358, 395, 411, 414, 421, 423  
Ackerman, N. W., 4  
Acute cases compared with chronic cases, 366  
Acute service, 344, 348, 350 t, 358, 420  
Administrative changes, patients' reactions to, 338, 349  
Advice-giving in early meetings, 134-136  
Age  
    of clinic patients, 40-41, 44-51, 66  
    effects of, on groups, 76-77  
    of hospitalized patients, 337, 339 t  
Aggressive patients, problems with, 486-487. *See also* Combative patients  
Alcoholics, problems with, 62, 66-67, 88-89, 226, 338  
Analysis  
    of recordings, 15  
    of data, quantitative vs. qualitative, 8  
Analytically oriented group therapy  
    definition of, 4  
    variations in, 324-329  
Antagonism. *See* Hostility  
Anxiety, 365, 417-418, 423, 449, 453  
    improvement in, 62  
    in early meetings, 379, 384  
    of doctors, 325, 335, 372, 435-436  
Attendance, 42, 43 t, 44-50, 53, 340-341  
Attitudes  
    toward hospitalization, 373-375  
    toward therapy, 142  
  
Bales, R. F., 16  
Behavior  
    categorizing meaning of, 17  
    Behavior (cont.)  
        of individual patients. *See* Running account, summary of  
Benedict, R., 17  
Bierer, J., 4  
Bion, W. R., 4, 318  
Brenman, M., 15  
Burchard, E. M. L., 4  
Burrow, T., 4  
  
Catatonics, 361-363, 420, 436, 446, 448, 488  
Categories in recording group meetings, 16  
Catholics, 42, 44-50, 55, 75-76, 121, 157, 239-240, 322  
Chronic cases compared with acute cases, 366  
Clinic groups  
    diagnoses of, 39-40  
    population of, 1, 39-44  
    psychotics in, 186-187  
    rosters of, 43 t, 44-51  
    schizophrenics in, 191-192, 377  
Clinic patients, group therapy with, 1-329  
Clinical records, 342, 372  
Closed groups, 39, 42, 66. *See also* Composition of groups  
Clowning in early meetings, 137-138, 368  
Cohen, M. R., 8  
Combative episodes, doctors' reactions to, 388  
Combative patients, 349, 351-352, 388, 390, 395, 397, 401, 410, 420, 422, 425, 453-454, 456, 479  
Communication  
    maintenance of, 466-467  
    problems of, in research staff, 3  
Competition  
    between doctors, 335



- Competition (cont.)  
   in early meetings, 134  
   *See also* Rivalry
- Complaints, similarity of, in early meetings, 136-137
- Compliance with doctor in early meetings, 130-132, 382-384
- Composition of groups, 105 t  
   clinic groups, 38-39, 66-112, 579  
   planned groups, 94-112  
   relation of, to drop-outs, 77-94  
   *See also* Age, Cultural background, Diagnoses, Education, Marital status, Racial composition, Religion
- hospitalized groups, 343, 359-368, 446, 466  
   based on diagnoses, 340-341, 343, 360-361  
   control patients for, 6, 337-338, 344  
   dominance and submission as criteria in, 363-364  
   therapeutic implications of, 367-368  
   *See also* Drop-outs
- Concentration, improvement in, 64
- Conferences. *See* Seminars
- Content of material presented, 5, 19, 26, 309
- Contraindications for group therapy, 193-194, 364
- Control patients for hospitalized groups, 6, 337-338, 344
- Cultural background, effects of, on group, 75-76
- Day rooms, observations of, 354-356
- Depression, improvement in, 62-64
- Diagnoses, 339 t  
   advantages of diversity of, in group composition, 365  
   of clinic patients, 39-40, 44-51, 66  
   relation of, to improvement, 61-65  
   of hospitalized patients, 337, 339, 343, 360-361  
   *See also under specific symptoms*
- Differences between patients, effects of, on groups, 67
- Directiveness of doctor in group, 72, 83-86, 88-89, 116, 226-227, 288, 528
- Discharges from hospital, 344, 345 t, 356, 395, 416, 425, 428
- "Discussion," in situation analysis, 30
- Doctors  
   at Perry Point Hospital, 334-336  
   characteristics of  
     related to therapy, 317-329, 361-362  
     *See also* Doctors, personal problems of  
   competition between, 335  
   conceptions of schizophrenia, 370-372  
   distrust of, in early group meetings, 378  
   experience of, 2  
     effects of, on therapy, 42, 78, 115, 118, 120, 122, 323, 327-328, 334-335, 495  
   inexperience of, difficulties resulting from, 78, 113, 120-124, 277, 280, 323-324, 335, 369-370  
   interventions of, summarized in running accounts, 23  
   number of, 2, 369  
   patients' reactions to attitudes of, 338  
   patients' stereotypes of, 205  
   personal problems of, 7, 10-12, 88, 113-114, 123, 131, 210-213, 218, 224, 227-228, 232, 321-322, 372, 435-436, 453, 488  
   qualifications of, 2  
   reactions of, to observers, 9-12, 116, 119-121, 317, 328, 390  
   responsibilities of, for conducting groups, 492  
   seen as omnipotent, 205, 219, 491  
   sex of, related to sex of patients, 363-366, 383-384, 446  
   sexual behavior toward, 365-366  
   techniques of  
     for cultivating doctor-patient relationships, 387-390, 396-397  
     for cultivating patient-patient relationships, 391  
   in early meetings, 276, 373-376, 385-391  
   with monopolists, 180  
   two present at same meeting, 299-301, 303-304  
   use of clinical notes by, in evaluating patients, 301  
   vacations of, 283  
   *See also* Goals, Hostility toward doctor, Interviews, Passivity, Relationships, Replacement of doctors, Rivalry, Women doctors

## Doctors, individual

Dr. A, 299-301, 448-450  
 Dr. Abrahams. *See* Group, large  
 Dr. B, 380, 394-410, 412-416, 420-434, 442-446, 450-459, 462-463  
     therapeutic techniques of, 396-397

Dr. D, 385

Dr. J, 418-420

Dr. K, 72, 82-84, 122-125, 135, 171-172, 183, 206-216, 249-251, 262-263, 286-287

    characteristics of, 325-326

Dr. L, 83, 88, 91-92, 118-120, 188-190, 311-312

    characteristics of, 326-327

Dr. M, 464

Dr. N, 69-72, 76-77, 84-86, 95-112, 125-129, 133-136, 143-160, 163-170, 173-179, 183, 195-198, 200-202, 206-207, 216-222, 242-248, 257, 260-262, 266-273, 278-279, 282-285, 299-300, 303-304, 307, 313-315, 495-530

    characteristics of, 327

Dr. P, 69, 75, 87, 120-122, 133-134, 136-137, 206

    characteristics of, 327

Dr. Q, 420, 426, 453-454

Dr. R, 185-186, 191

    characteristics of, 328

Dr. X, 68, 77, 88-89, 115-118, 226-228, 288-290, 327, 571

    characteristics of, 328

Dr. Y, 380, 410-412, 416-417

Dr. Z, 89-91, 135, 186-188, 222-225, 248-249, 255-256, 291, 294, 328-329

*See also* Groups, individual

Dominance and submission as criteria in group composition, 363-364

Drop-outs, 42, 52, 77-94. *See also* Treatment, termination of

Duration of treatment. *See* Treatment, duration of

Dynamics, group, 4, 18, 22-23, 26, 28, 35, 323-324, 488-490, 511, 528. *See also* Process

Dynamics, individual. *See* Psychodynamics

## Early meetings

    advice-giving in, 134-136

    clowning in, 137

    compared with later meetings, 141-144, 232

## Early meetings (cont.)

    complaints in, similarity of, 136-137

    compliance in, 130-132, 382-384

    doctors' activity in, effects of, 113-140, 373-376, 385-391

    doctors' techniques in, 373-376, 385-391

    patients' reactions to absences in, 386

    patients' reactions to doctor in, 129-132, 373-390

    patients' reactions to other patients in, 114, 129, 132-138, 381-382, 384-385, 391

    problems of, 131-140, 369-391

    questions concerning therapy in, 114

    running accounts of, 495-513

    seating positions in, 377

    therapeutic implications of, 138-140

*See also* Anxiety, Competition, Hostility, Resistance, Rivalry

Education, 40-41, 44-51, 66, 116, 118, 123

    effects of differences in, 73-75

Effectiveness, patients' improvement in, 64

"Effects," in situation analysis, 29-30

Electric shock treatment. *See* Shock treatment

Erotic interest in doctor, 363

Evaluation. *See* Improvement, methods of evaluating; Patients, methods of evaluating

"Event," in situation analysis, 29

Experienced doctors. *See* Doctors, experience of

Experimental ward patients

    progress of, compared with that of control patients, 344

    sensitivity of, to doctors' attitudes, 338

Experimental wards, population of, 337-338

Fiske, D. W., and Kelly, E. L., 531

Foulkes, S. H., 4

Frank, J. D., 2

"Freedoms" of hospitalized patients, 344-347

French, J. R. P., Jr., 6, 24

Gate passes for hospitalized patients, 344, 345 t, 346, 416

Gifts offered or received by doctor, 388-389

Gill, M. M., 15

## Goals

of doctor for group meetings, 23, 26, 510-511, 528

of research, 6

of treatment, 5, 15

Grounds privileges, 344, 345 t, 346, 356, 423, 433

Group, large, 335-336, 466-492

composition of, 466

course of therapy in, 469-471

therapeutic implications of, 490-492

Group dynamics. *See* Dynamics, group

Group interaction, ways of promoting, 488-490

Group meetings, 43 t, 340 t

duration of, 9, 39

enjoyment of, 377-378

frequency of, 39, 343

total number observed, 42-43, 340 t  
with two therapists, 299-301, 303-304

Group members. *See* Patients

Group mores, 128, 142, 186, 290, 397-398, 469, 511

Group process. *See* Process, group

Group silences. *See* Silences

## Group therapy

advantages of, 218, 251, 254, 272-273

after individual therapy, 283

and individual therapy, 10-11, 61, 64, 232-234, 315-316, 320, 325, 393, 434, 448

anticipatory reactions to, 53, 379

concomitant with individual therapy, 39, 42, 43 t, 44, 58-60, 146, 163, 176, 192, 211, 213, 217, 248,

251, 272-273, 283, 287-288

contraindications for, 193-194, 364

doctors' anxiety in, 325

effects of, on hospital staff, 337-338

history of, 1

relation of, to individual therapy, 32-33, 306-316, 342

relative effectiveness of group and individual therapy, 58-59

types of, 4, 5

## Groups

early meetings of, 131-144, 232, 369-391, 495-513

## Groups (cont.)

later meetings of, 141-161, 232, 513-530

complete running account of, 513-530

contrasted with early meetings, 141-144, 232

number of, 42, 43 t, 340 t, 343, 369

reasons for closed, 281

replacement of doctors in. *See* Replacement of doctor

size of, 42, 43 t, 340 t, 359-360, 365

## Groups, individual

Dr. A's group (III), 340 t, 448-450

Dr. Abrahams' group. *See* Group, large

Dr. B's group (v-b), 377-378, 381, 383, 395-410, 412-416, 442-446,

450-459, 462-463

composition of, 395

Dr. B's group (vii-b), 379, 382-383, 385

Dr. F's group (xii), 340 t, 378, 380, 382-384, 387, 390

Dr. G's group (viii), 340 t

Dr. G's group (xi), 340 t, 379

Dr. J's group (i), 340 t, 377, 381, 418-420

Dr. K's group, 43 t, 44-45, 72-73, 81-84, 122-125, 134-135, 171-

173, 183, 206-216, 249-251, 262-263, 286-288

Dr. L's group, 43 t, 45, 73-74, 83, 87-88, 91-92, 118-120, 131-132,

188-190, 310-312, 578

Dr. M's group (ix), 340 t, 380-381, 384, 464-465

Dr. N's Group I, 43 t, 45-46, 73, 75-76, 145-160, 163, 173-179, 200-

203, 206-207, 216-220, 235-239, 268-273, 278, 307, 313-315, 573

Dr. N's Group II, 43 t, 44, 46, 52, 70-72, 76-78, 83-86, 92, 111-112,

135-136, 142-144, 163-169, 183, 192-193, 220-222, 236, 241-243,

256-257, 278-280, 282-285, 303, 567-569, 577, 580, 584-587

complete running accounts of, 495-530

Dr. N's Group III, 42, 43 t, 44, 47, 52, 76, 86, 95-112, 125-129, 132,

169-170, 195-198, 243-248, 260-262, 266-267, 299-301, 303-304,

574, 579

## Groups, individual (cont.)

Dr. N's Group iv, 43 t, 47, 52, 95-112, 130

Dr. O's group (ii), 340 t

Dr. P's Group i, 43 t, 47-48, 69, 74-75, 86-88, 120-122, 131, 133-134, 199-200, 278

Dr. P's Group ii, 43 t, 48-49, 75, 136-137, 206

Dr. Q's group (v-a), 340 t, 420, 426, 453-454

Dr. R's Group i, 43 t, 49, 184-186, 191-192

Dr. R's Group ii, 43 t, 49-50

Dr. U's group (vi-a), 340 t

Dr. V's group (x), 340 t

Dr. W's group (vi-b), 340 t, 383

Dr. X's group, 43 t, 50, 67, 77-78, 88-89, 92, 115-118, 132, 226-228, 288-290, 574

Dr. Y's group (vi-a), 378-381, 384-385, 390, 410-412, 416-417, 460-462

Dr. Z's group, 43 t, 50-51, 89-91, 135, 186-188, 222-225, 248-249, 254-256, 290-291, 294

*See also* Doctors, individual

Guilt feelings, improvement in, 64

Hebephrenics, 361, 446, 487-488

Homosexual feelings aroused in group, 214, 250-251, 309, 376, 414, 422, 434

Homosexuality, 124, 171-172, 217, 368, 395, 425, 478, 481, 483-484, 491

problems created by, 238, 271, 322, 362, 365-366, 420, 424, 460-462.

*See also* Positive feelings

Horney, K., 554

Hospital administration, relation of, to this research, 336, 342

Hospital staff, reactions of, to group therapy research, 337-338

Hospitalization, duration of, 337, 339 t

Hospitalized groups

composition of. *See* Composition of groups

number of, 340 t, 343

population of, 1-2, 337-343

schizophrenics in, 333-492

Hospitalized patients

"freedoms" of, 344, 345 t, 346-347

group therapy with, 333-492

measures used to control, 347-349, 350 t

## Hospitalized patients (cont.)

social work interviews with, 558-559

statistical summaries on, 344-358

Hostility, 320-321, 379, 448-460, 491

between patients, 32-33, 146, 164, 190, 200-202, 234-253, 278, 285, 381-382, 399, 404, 414-415, 423, 426, 433, 476

therapeutic implications of, 251-253

forms of expression of, 13, 202, 392-393, 448

toward doctor, 132, 143-144, 149, 163, 178, 200-202, 205-227, t facing 228, 229, 230 t, 232-233, 285, 302, 326, 365, 379-382, 388, 408-409, 411, 418, 421, 423, 427-428, 446, 454, 460-461, 483, 511, 516, 529-530

doctor's reaction to, 320-321, 326, 361-362, 388

relation of, to individual sessions, 315

relation of, to rivalries, 404, 408-409

therapeutic implications of, 228-233, 459-460

*See also* Doctors, personal problems of

Hydrotherapy. *See* Packs and tubs

Illness, duration of, 40-41, 44-51

Improvement, 59-62, 63 t, 64-65, 345-346, 348-349, 352-354, 356-358

areas of, 61, 63 t

degree of, 57, 61-62, 63 t, 64

methods of evaluating, 6, 55-58, 344-349, 351-352, 354-355, 551-552, 560-563, 579-591

relation of, to diagnosis, 61-62

relation of, to duration of treatment, 60-61

relation of, to type of treatment, 59, 63 t, 64

Incontinence, 351-352, 353 t, 358

Individual differences, effects of, on groups, 67-77

Individual therapy

after group therapy, 79-81, 87, 89, 91, 291

and group therapy. *See* Group therapy, and individual therapy



- Individual therapy (cont.)  
 experience in, as aid in leading groups, 329  
 indications for, 193-194  
 prior to group therapy, 52, 119, 123, 125, 128, 283, 288, 337, 372, 495, 529  
 requests for, 301  
 sessions of  
   number of, 42  
   referred to in group, 190, 262-263, 311-312
- Inexperienced doctors. *See* Doctors, inexperience of
- Inferences, 15, 20-22, 496-509, 514-527
- Insulin shock. *See* Shock treatment
- Intelligence as factor in group composition, 66
- Interaction, group. *See* Group interaction
- Interpersonal-relations interviews, 1, 6, 9, 38, 55-56, 84, 130, 134, 553-564  
   in composing groups, 95, 112, 560  
   in determining patients' reactions to group, 563-564  
   in evaluating treatment results, 560-563  
   in studying drop-outs, 80, 84-87  
   with hospitalized patients, 558-559
- Interviews between doctors and observers, 3, 22-23, 335, 453  
   post-meeting, 10, 15, 18, 22-23, 510, 513, 528-530  
   pre-meeting, 10, 386
- Isolated patients, group therapy for, 65
- Jealousy. *See* Rivalry
- Jews, 42, 44-50, 54-55, 75-76, 99-100, 110, 153, 237-239, 266-267, 271, 309, 322
- Kelly, E. L., and Fiske, D. W., 531
- Klapman, J. W., 4
- Later meetings. *See* Groups, later meetings of
- Lazell, E. W., 4
- Leadership, problems of, 318-320
- Lewin, K., 16
- Life experience. *See* Age
- Maas, H. S., 112
- McNemar, Q., 345
- Mann, J., 5, 317
- Marital status of clinic patients, 40-41, 44-51, 66
- Masturbation as problem in group, 465
- Mature groups. *See* Groups, later meetings of
- Mechanical recording. *See* Wire recording
- Meetings. *See* Groups, early meetings of, later meetings of
- Memory, improvement in, 64
- Men patients compared with women, 365-366
- Mental Hygiene Clinic (V.A.), Washington, D. C., 1, 38, 325, 342, 377, 549
- Military service of clinic patients, 40-41, 44-50
- Monopolies, therapeutic implications of, 179 t, 180-181, 193-194
- Monopolists  
   in clinic groups  
     habitual, 162-163, 181-194  
     occasional, 162, 166-181  
   in hospital groups, 362, 395, 425
- Mores of group. *See* Group mores
- Motor activity, 357 t  
   method of rating, 354-356
- Murray, H. A., 5
- Nagel, E., 8
- Narrative accounts, 16. *See also* Running accounts
- Negroes, 42, 47-48, 54-55, 75
- New members of groups, 192-193, 263, 281-297  
   therapeutic implications of, 294-297  
   *See also* Open groups
- Nurses, ratings of patients by, 336-337, 343-344
- Observations  
   of clinic groups. *See* Clinic groups  
   of hospitalized groups. *See* Hospitalized groups  
   of ward day rooms, 354-356
- Observed groups  
   total number of, at clinic, 42, 43 t  
   total number of, at hospital, 340 t, 343
- Observers  
   accuracy of reports by, 539 t  
   completeness of reports by, 537 t  
   doctors' reactions to, 9-12, 116, 119-121, 317, 328, 390  
   duties of, 3, 9, 19



- Observers (cont.)  
 evaluations of patients by, 3, 55-65, 550-551. *See also* Improvement, methods of evaluating  
 group meetings reported by, 15-23.  
*See also* Observers' reports  
 identification of, with patients, 14  
 introduction of, to group, 107, 386, 496  
 participation of, in seminars, 9  
 patients' reactions to, 12-14, 186, 289, 384, 386, 411, 429, 437, 439, 449, 454, 461  
 preparation of situation analyses by, 23-37  
 qualifications of, 14-15  
 relationship of, with group, 12, 13  
 reliability of, 540 t, 541 t, 547 t  
 role of, in this research, 2  
 selectivity of, 17, 531  
 time required of, 9
- Observers' reports  
 compared with wire recordings, 532-543  
 completeness and accuracy of, 531-548  
 reliability of, 532, 536-538, 540-548  
*See also* Running accounts
- Occupations of clinic patients, 40-41, 44-51
- Open groups, 39, 66, 192. *See also* Composition of groups
- Outpatient groups. *See* Clinic groups
- Packs and tubs, 342, 344, 347-348, 350 t, 351, 426
- Panic states, improvement in, 62
- Paranoids  
 in clinic groups, 69, 75, 328  
 in hospitalized groups, 361-362, 436, 446, 486-487
- Passivity of doctor in relation to therapy, 72, 82-84, 90-91, 123-124, 134, 146, 208, 262, 318-319, 375, 418
- Patients  
 characteristics of, in relation to doctor, 361-364  
 distrust of doctor by, 378  
 effect on group of differences in, 67-77  
 methods of evaluating, 3, 5-6, 55-58, 549-551, 553-583  
 method of rating ward interactions of, 355-356
- Patients (cont.)  
 presenting special problems in groups, 162-194, 364. *See also* Alcoholics, Catatonics, Monopolists  
 reactions of, to observers. *See* Observers, patients' reactions to  
 relationships of. *See* Relationships  
 screening of, 38  
 seating positions of, 182, 377  
 transfer of, to new groups, 283  
 women compared with men, 365-366
- Patients, individual  
 Aggerston, 138  
 Akers, 95-96, 104-105, 107-111, 125-129, 131-132, 260, 266-267  
 Alban, 96-97, 105, 108-109, 111, 137, 169-170  
 Allen, 191-192  
 Ames, 418-419  
 Barkert, 479, 489  
 Barnes, 116-118  
 Basmit, 483  
 Bassom, 311  
 Beaman, 395, 467, 470-472, 477-487  
 Berg, 418-420, 467-468, 474, 484  
 Blake, 191  
 Bly, 70-72, 86, 143-144, 164, 183, 192-193, 220-222, 236-237, 278-280, 282-285, 295, 303, 495, 497-519, 522-529, 577, 585, 587  
 Bonner, 448-449  
 Boyden, 81-84, 93-94, 123, 262-263, 286-288  
 Bridges, 29, 34-35, 76, 97-98, 104-105, 108-110, 130, 169-170, 195-198, 243, 245-247, 260-262, 266-267, 295  
 Brindel, 418-419  
 Brink, 418-419, 468-474, 476-479, 482-486  
 Bush, 119-120, 188  
 Camp, 105  
 Canfield, 105  
 Cann, 98-99, 105-111, 125-129, 132, 169, 195-198, 243-247, 260-262, 266-267, 295, 299-300, 303-304  
 Castell, 70-72, 192, 220-221, 282-285, 513, 516, 519-521, 529, 568-569, 576  
 Caster, 116-118, 321  
 Cerotti, 410, 416-417, 441

## Patients, individual (cont.)

Charles, 87-88, 119-120, 182, 188,  
310-311  
Charmer, 383  
Clover, 74, 121  
Cole, 77, 321  
Compton, 464-465  
Conner, 91, 131  
Cook, 86-88, 93, 199-200  
Coombs, 27, 29, 34-35, 70-71, 75-  
76, 135-136, 146-149, 151-160,  
173-175, 177-178, 183, 192-193,  
200-202, 216-220, 235-237, 239-  
240, 268-272, 278-280, 282-285,  
295, 313-315, 513-514, 516-526,  
528-529, 572  
Crosby, 136-137  
Cursey, 418-420, 468-469, 473-474,  
476, 478-480, 484-485, 489  
Deems, 410, 417  
Dobbs, 418, 478, 481  
Doon, 88, 571  
Dugan, 92-93  
Dupont, 85, 166-168, 241, 256, 495,  
500-501, 512  
Dwight, 481  
Eubank, 146-151, 153, 155, 157,  
160, 173, 175-178, 200, 202, 216,  
218-219, 268-270, 313-314  
Fisca, 84-86, 92-93  
Flounder, 163-166  
Flower, 85-86, 166-168, 495, 503,  
512, 586  
Footen, 410, 417, 436, 474-479,  
482-483, 485  
Frasher, 384  
Freedman, 119-120, 188, 310  
Furnas, 410-412, 416-417, 441, 461  
Gans, 468-470, 472-476, 482, 485  
Giordano, 186-187, 222-225, 254-  
256  
Goodfriend, 76, 86, 99-100, 104-  
105, 107-110, 125-128, 195-198,  
243, 245, 260-261, 266-267, 299-  
302, 574  
Gorley, 137  
Grey, 67-68, 116-118, 226-229, 288-  
289, 295  
Grimm, 410, 416-417  
Gugis, 147-155, 157-160, 173-178,  
200-202, 216-220, 270-271, 313  
Hamling, 119-120, 188, 311-312  
Hammond, 123-124, 135, 206, 207-  
213, 262-263, 286

## Patients, individual (cont.)

Hampton, 481  
Handen, 418-419  
Happ, 136-137  
Hare, 144, 241-243, 256-257, 495-  
500, 502-512, 586  
Harms, 441  
Hastings, 67-68, 77, 226-228  
Hawks, 384  
Hilman, 468, 471-478, 480, 482-  
483, 485  
Holman, 472  
Holston, 448-449  
Hurford, 73-74  
Incliffe, 74-75, 87, 121, 199-200  
Ingram, 70-72, 76, 83-84, 135-136,  
143-144, 163-166, 183, 192-193,  
220, 237, 241, 256-257, 279-280,  
282-285, 495, 500-503, 512-514,  
516-519, 522-529, 567  
Janeway, 88-89, 92-93, 288-290, 295  
Juelks, 472  
Kapp, 121-122, 199-200  
Keefer, 448-449  
Kight, 395, 402-403, 412-414, 421,  
451, 472-473  
Kootch, 222-225, 248-249, 291,  
294-295  
Kroll, 472-473  
Lake, 448-449  
Lanski, 410-412, 416-417, 441, 461-  
462, 481  
Leister, 448-449  
Lobas, 477, 479-480, 483, 485  
Malta, 72-73, 183, 210-211  
Mason, 84-86, 93, 143-144, 241,  
256, 495-496, 499-512, 585  
Mercer, 171-172, 207, 209-215, 249-  
251, 286-288  
Merrick, 74-75, 121-122, 131, 133-  
134, 199, 278  
Meynert, 418  
Michaels, 105  
Milton, 147-151, 153-155, 157-160,  
163, 173-175, 177-179, 200-201,  
216-219, 239-240, 268, 270, 272,  
313  
Minor, 29, 34-35, 86, 100-101, 104-  
105, 107-111, 125-129, 131-132,  
169-170, 195, 198, 243-248, 260-  
262, 266-267, 295, 299-303  
Mr. S., 380-381  
Monroe, 286-288, 295  
Montgomery, 226, 228, 290

## Patients, individual (cont.)

Moore, 116  
 Mulican, 171-172, 210-212  
 Munsey, 395, 406  
 Murdock, 395, 406-408, 428, 430-432, 442  
 Nellis, 395, 399-403, 412-416, 421, 423, 442-445, 451  
 Norrison, 448-449  
 Null, 495, 497, 503, 506-507, 509-512  
 Olds, 448-449  
 Olem, 89-91, 93, 254-256  
 Paley, 105  
 Palmero, 410, 417, 460-461  
 Parham, 478  
 Peterson, 105  
 Phillips, 186, 222-225, 248-249, 291, 294, 295  
 Pim, 143-144, 495, 497-505, 507-508, 510, 513  
 Flux, 104-105  
 Potts, 105  
 Randall, 77  
 Ransom, 178-179  
 Reiser, 89-91, 254-256  
 Rice, 226, 228, 321  
 Rosen, 89-91, 93, 135  
 Rothschild, 184-185, 171, 206, 210-214  
 Rutherford, 418-419, 468-469, 471-478, 481-484, 485, 489  
 Samuels, 395, 399-407, 409-410, 412, 414-415, 420-433, 442-446, 451, 454-459, 474-478  
 Sands, 418-419  
 Sansom, 395, 404-407, 427-428, 431, 442-445  
 Scuffy, 185-186  
 Segonia, 395, 409-410, 426-434, 450, 452, 462-463  
 Seidel, 445-446  
 Sheller, 472, 474, 477-479, 485  
 Sherry, 472  
 Simmers, 474  
 Sleich, 91-93  
 Sloane, 171, 210-211  
 Small, 101-102, 104-105, 108, 110, 195-197, 260-261, 266-267  
 Speek, 468  
 Stafford, 186-188, 222-225, 254-256, 291, 294-295  
 Steele, 72-73, 123-124, 207-209, 262-263, 286-287, 295

## Patients, individual (cont.)

Stern, 75, 133-134, 206, 304  
 Stieff, 395, 399-402, 404, 420-426, 443  
 Stole, 418  
 Stone, 102, 105, 108, 111, 169, 299-301  
 Street, 77, 116, 118, 137-138  
 Stumpf, 474, 479-481, 483-485, 489  
 Sweet, 477-478, 480, 484  
 Talbot, 475-476, 480  
 Teaney, 144, 495, 497, 499-501, 503-504, 510-511, 513, 585-586  
 Terry, 191  
 Thaddeus, 69  
 Theodore, 211  
 Thomas, 86, 166-168, 241-243, 256-257, 585-587  
 Throck, 74, 119-120, 188-190, 310  
 Tile, 77, 116-118, 574  
 Tiller, 477  
 Tower, 453-454  
 Trill, 81-84, 93-94, 207-209, 287  
 Trippitt, 29, 75-76, 146-160, 163, 173-177, 200-202, 206-207, 216-219, 235, 237-239, 268-273, 313-314  
 Turner, 123-124, 171-172, 206-215, 249-251, 262-263, 286-287, 295  
 Veal, 70, 85, 144, 183, 192, 220-222, 282-283, 285, 513, 517, 525-530, 568  
 Weber, 73, 201, 237-239, 268-271  
 Weems, 395, 412, 414, 422, 425, 428, 430, 432, 445-446  
 West, 171-172, 207-211  
 Westerly, 464  
 Whittel, 395, 443-444  
 Winston, 83, 119-120, 188, 578  
 Worden, 395, 399-400, 445-446  
 Wyman, 81-84  
 Zachary, 395, 402-404, 406, 421, 430, 442-446, 452-455, 458-459  
 Perry Point Hospital (V.A.), 1-2, 340 t, 344  
     patients treated at, 1-2, 333-492  
 Personality trends, improvement in, 64-65  
 Pfeffer, A. Z., 89  
 Phobias, 62, 77  
 Physical attack. *See* Combative episodes, Combative patients  
 Planned groups, 94-112. *See also* Composition of groups

- Population  
 of clinic groups, 1, 39-44  
 of control wards, 337-338  
 of experimental wards, 337-338  
 of hospitalized groups, 1-2, 337-343
- Positive feelings  
 between patients, 249-251, 272-273, 309  
 toward doctors, 381  
*See also* Homosexual feelings
- Powdermaker, F. B., 2
- "Precipitating event," in situation analysis, 29
- Prediction of group behavior  
 by interpersonal-relations interview, 560  
 by psychological tests, 578-579
- Preparation of patients for group therapy, 51-55, 372-376
- Process, group, 5, 18, 23, 36-37. *See also* Dynamics, group
- Processes of therapy, 1
- Psychiatric residents  
 as observers, 336  
 as therapists, 334-335  
*See also* Doctors
- Psychiatrists  
 evaluation of patients by, 549-552  
 evaluation of patients' improvement by, 55-65  
 role of, in this research, 2, 334-336  
*See also* Doctors
- Psychodynamics, 18-19, 22-23, 26, 511-513, 529-530
- Psychological tests  
 characteristics revealed by, 6, 89, 97  
 in composing groups, 95, 99-102, 112, 577-579  
 in evaluating results of treatment, 6, 55-56, 579  
 in studying drop-outs, 80, 84, 87  
*See also* Rorschach Test, Thematic Apperception Test, Wechsler-Bellevue Test
- Psychologists  
 methods used by, 55-56, 565-579  
 observations of ward day room by, 354-356  
 roles of, in this research, 2, 3, 9, 38, 55-58
- Psychotics  
 effects of treatment on, 62, 65  
 group therapy with, 333-492  
 in clinic groups, 69, 147, 186-187, 222-225
- Psychotics (cont.)  
 in hospitalized groups, 333-492  
*See also* Catatonics, Paranoids, Schizophrenics
- Racial composition of clinic groups, 42, 44-50, 75-76
- Rallying topics, 25, 124-125, 195-204, t facing 204, 284-285
- Rating scales in recording group meetings, 16
- Reactions of patients to doctors and to other patients. *See* Early meetings
- Recording group meetings  
 facilitating patients' activity by, 13  
 methods of, 9, 15, 336  
 use of categories in, 16-18  
*See also* Running accounts, Wire recording
- Refusals to attend group meetings, 423, 453
- Relationships  
 observer-doctor, 9  
 patient-doctor, 26, 53, 387-390, 396-397  
 patient-patient, doctors' techniques for fostering, 391
- Religion of clinic patients  
 effects of differences, 75-76  
 statistics for, 40, 42, 44-50  
*See also* Catholics, Jews
- Remission as reaction to rivalry, 404, 420, 426
- Replacement of doctor, therapeutic implications of, 69, 132-134, 298-305, 335, 363, 380, 385, 420, 426
- Reports of group meetings. *See* Running accounts
- Research  
 goals of, 6  
 methods of, 5, 6  
 problems in psychotherapeutic, 7-8
- Research staff, function of, 1-4, 336
- Research team, collaboration of, 3-4, 55-57, 580
- Resistance  
 forms and resolution of, 254-280  
 in early meetings, 384  
 of individual patients, 258 t  
 therapeutic implications of, 273, 276-277  
 to joining groups, 53-55, 248, 376  
*See also* Silences
- Responses to stimuli as indicators of improvement, 57



- Results of treatment. *See* Improvement
- Rivalry, 309-310, 392-434, 523  
     challenger patient in, 397-399, 401, 403, 442  
     in early meetings, 130, 132-134, 382, 388  
     in the large group, 471, 491  
     lead patient in, 397-399, 401, 403, 442  
     related to anxiety, 417  
     types of situations in, 397-399
- Rogers, C., 16
- Rorschach test, 56, 343, 565-579, 582-583. *See also* Psychological tests
- Rosters of clinic groups, 43 t, 44-51
- Rumination, improvement in, 62
- Running accounts, 18, 23-24, 42, 111-112, 342, 495-530  
     completeness and accuracy of, 20, 531-536, 537 t, 538, 539 t, 540-548  
     description of, 19-21  
     inferences in. *See* Inferences  
     reliability of, 532, 536-538, 540 t, 541 t, 542-546, 547 t, 548  
     selectivity in, 19-21  
     summary of, 15, 22-23  
     *See also* Recording group meetings
- Schilder, P., 4
- Schizoid patients, as interpreters of psychodynamics, 327
- Schizophrenics  
     doctors' conceptions of, 370-372  
     group therapy with, 333-492  
     in clinic groups, 136-137, 147, 191-192, 270, 291, 313, 321, 377  
     reactions to group therapy, 378-380  
     reactions to other patients, 376-377, 382, 384, 391. *See also* Hostility, Sexual behavior  
     *See also* Catatonics, Paranoids
- Seating positions of patients, 182, 377
- Seclusiveness, improvement in, 64
- Sedation of hospitalized patients, 342, 344, 347-349, 350 t
- Selection of patients for group. *See* Composition of groups
- Self-confidence, improvement in, 64
- Self-depreciation, improvement in, 64
- Seminars, 3, 5, 9-10, 20-21, 37, 56-57, 113, 324, 550
- "Setting," in situation analysis, 28
- Sex of patients in relation to sex of doctor, 363-366, 383-384, 446
- Sexual behavior  
     meanings of, 489-490  
     therapeutic implications of, 465  
     toward doctor, 365-366
- Sexual content related to doctor's attitudes, 322
- Sexual fantasies involving doctor, 363, 383, 388, 428
- Sexuality, 448, 460-465  
     reactions to discussion of, 417-418  
     related to hostility, 450
- Sexualization of speech, 438
- Shock treatment, 337, 342-344, 347-349, 350 t, 351, 358, 374, 379, 426
- Silences, 200-203, 277-280, 417, 435-447  
     in early group meetings, 138, 226, 277, 386  
     reactions of doctors to, 277, 280, 321, 435-436, 446  
     related to group composition, 446  
     related to hostility, 229, 277  
     related to "mulling over" and "digestion," 277  
     related to sex, 438  
     techniques for handling, 267-270, 276, 280, 439-442
- Similarity of patients, effect of, on group, 67-68
- Situation analyses  
     definition of, 6, 24  
     differences between those in Parts I and II, 399  
     "discussion" defined, 30  
     "effects" defined, 29  
     "event" defined, 29  
     form of, 27-29  
     list of, xiii  
     "precipitating event" defined, 29  
     problems in classification, 36  
     selection of situations for, 23-26, 30  
     "setting" defined, 28  
     "tentative deductions" defined, 30, 34-36  
     validation of, 30-36
- Situation analyses, individual  
     comparison of (S.A. 39, 26), 32 t  
     early meetings (S.A. 2), 125-129, t facing 204, 264 t  
     habitual monopolist  
         (S.A. 9), 186-188  
         (S.A. 10), 188-190  
         (S.A. 11), 192-193
- hostility  
     (S.A. 54), 448-449  
     (S.A. 55), 451



# Situation analyses, individual, hostility (cont.)

(S.A. 56), 452-453

(S.A. 57), 453-454

(S.A. 58), 454-455

(S.A. 59), 455-458

(S.A. 60), 458-459

## hostility between patients

(S.A. 24), 241-243

(S.A. 25), 243-245

(S.A. 26), 32 t, 245-248

## hostility toward doctor

(S.A. 15), 207-210, t facing 228

(S.A. 16), 210-211, 230 t

(S.A. 17), 211-213, 230 t

(S.A. 18), 213-216, t facing 228

(S.A. 19), 216-218, t facing 228

(S.A. 20), 218-220, t facing 228

(S.A. 21), 220-222, t facing 228

(S.A. 22), 222-225, t facing 228

(S.A. 23), 226-228, 230 t

(S.A. c), 230 t

## individual differences and the group situation (S.A. 1), 70-72

## introduction of new members

(S.A. 34), t facing 204, 282-285

(S.A. 35), 286-288, 292 t

(S.A. 36), 288-290, 292 t

(S.A. 37), 291, 294

## occasional monopolist

(S.A. 3), 166-169, t facing 180

(S.A. 4), 169-170, t facing 180

(S.A. 5), 171-173, t facing 180

(S.A. 6), 173-175, t facing 180

(S.A. 7), 175-178, t facing 180

(S.A. 8), 178-179, t facing 180

## rallying topics

(S.A. 2), 125-129, t facing 204, 264 t

(S.A. 12), 195-198, t facing 204

(S.A. 13), 199-200, t facing 204

(S.A. 14), 200-203, t facing 204

(S.A. A), t facing 204

(S.A. B), t facing 204

# Situation analyses, individual (cont.)

## relations between individual and group therapy

(S.A. 38), 311-313

(S.A. 39), 32 t, 313-315

## resistance of individual patients

(S.A. 2), 125-129, t facing 204, 264 t

(S.A. 27), 254-256, 258 t

(S.A. 28), 256-257, 258 t

(S.A. 29), 260-262, 264 t

(S.A. 30), 262-263, 264 t

(S.A. 31), 266-267, 274 t

(S.A. 32), 268-270, 274 t

(S.A. 33), 270-273, 274 t

(S.A. D), 264 t

## rivalry

(S.A. 40), 399-400

(S.A. 41), 400-401

(S.A. 42), 401-402

(S.A. 43), 403-404

(S.A. 44), 404-405

(S.A. 45), 406-408

(S.A. 46), 409-410

(S.A. 47), 410-412

(S.A. 48), 412-416

(S.A. 49), 416-417

(S.A. 50), 418-420

## sexuality

(S.A. 61), 462-463

(S.A. 62), 463

(S.A. 63), 464-465

## silences

(S.A. 51), 442-443

(S.A. 52), 443-445

(S.A. 53), 445-446

## Size of group, 42-43, 359-360, 365

Slavson, S. R., 4, 318, 554

## Social relations

as indicators of improvement, 57  
improvement in, 64-65

## Social workers

evaluation of treatment by, 3, 56, 549, 553-564

interviews by. *See* Interpersonal-relations interviews

observations of ward day room by, 354, 356

patients' reactions to, 223

roles of, in this research, 2-3, 9, 38, 55-58

## Somatic complaints, improvement in, 62

Spontaneous purposeful activity, method of rating, 355-356, 357 t

- Staff members, collaboration of, 3-4, 55-57, 335-337, 580
- Stammerers, 44, 72-73, 124, 164, 181-183
- Statistical summaries  
  of clinic patients, 39-43, 55-65  
  of hospitalized patients, 344-358
- Submission and dominance, as criteria in group composition, 363-364
- Sullivan, H. S., 24
- Supervisory psychiatrists, 3
- Symptoms  
  as indicators of improvement, 57  
  improvement in, 57, 62-65, 550
- Teaching program  
  for inexperienced doctors, 334-335  
  *See also* Seminars
- Tension  
  catatonic reaction to, 362  
  encouraging monopoly to relieve, 180  
  related to hostility, 178, 285  
  related to rallying topics, 284-285  
  related to themes, 144-161  
  rise and fall of, 145  
  *See also* Hostility, Monopolists, Rallying topics, Themes
- "Tentative deductions," in situation analysis, 30, 34
- Termination of groups, 43-44
- Termination of treatment, 78-94. *See also* Drop-outs
- Tests. *See* Psychological tests
- Thematic Apperception Test, 565, 582
- Themes  
  analysis of long-term processes, 36-37, 144-145  
  group, 491  
  related to tension, 144-161
- Therapeutic philosophy of this study, 5
- Therapeutic techniques. *See* Doctors, techniques of
- Therapists. *See* Doctors
- Therapy, styles of, 324-329
- Thomas, W. I., 24
- Transferring groups. *See* Replacement of doctor
- Treatment  
  duration of, 43 t, 60-61, 79, 340, 343, 350  
  improvement in relation to length of, 60-61  
  termination of. *See* Termination of treatment
- Trial visits, 344, 345 t
- Vacations, effects of doctors', 283. *See also* Absence of doctor
- Veterans Administration Mental Hygiene Clinic. *See* Mental Hygiene Clinic
- Visitors, patients' reactions to, 14, 289, 417, 516, 529
- Washington Mental Hygiene Clinic. *See* Mental Hygiene Clinic
- Ward behavior of hospitalized patients, 433
- Ward management, problems of, 349, 351-354
- Wards, observation of, 354-356
- Wechsler-Bellevue Test, 565
- Wender, L., 4
- Wire recordings, 15-16, 20, 107  
  compared with observers' reports, 532-543  
  of schizophrenic groups, 532  
  *See also* Running accounts
- Women doctors, patients' reactions to, 363-366, 383-384, 446
- Women observers, in groups of men, 13-14, 289
- Women patients  
  compared with men, 365-366  
  reactions of, to doctor of opposite sex, 365-366
- Wolf, A., 4
- Znaniecki, F., 24





















Form No. 3.

PSY. RES.L-1

**Bureau of Educational & Psychological  
Research Library.**

The book is to be returned within  
the date stamped last.

27 OCT 1964

[illegible]

131.322  
pow

Form No. 4

BOOK CARD

Coll. No. 131.322

Accn. No. 682

Author powdermaker, F.B.

Title Group psychotherapy;

Date.

Issued to

Returned on

27 OCT 1961

8/9

1707

131.322  
pow



